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ABSTRACT

Fifteen papers address issues in therapeutic recreation for disabled persons from the perspectives of practitioners, educators, and students. The following papers are presented. "Therapeutic Recreation Service: The Past and Challenging Present" (H. Sessoms); "Therapeutic Recreatiion in an Era of Limits: A Crisis...A Challenge... An Opportunity" (K. Halberg); "Living Up to the Name: Research Support for Therapeutic Recreation Service" (J. Dixon and D. Dustin); "The Formative Program Evaluation Procedure: An Internal Evaluation Tool for Therapeutic Recreation Services" (P. Connolly); "Status of the Therapeutic Recreation Professional: Unit Directors' Perceptions" (J. Witman and L. Powell); "The Effects of a Treatment Program for Chronic Pain Patients Using Relaxation Techniques, Enjoyable Imagery, and Biofeedback" (P. Mckee); "Some Uses of the Multi-modal Model of Curriculum Evaluation in Therapeutic Recreation" (C. Howe); "A Study to Determine the Educational Level and Practical Experience of College Teachers in Therapeutic Recreation: 1980" (S. Smith and R. McGowan); "Systematic Curriculum Development" (S. Anderson and H. Finch); "Creativity: Strategies for Innovative Teaching and Parenting" (C. Stensrud); "Attribution Theory in Therapeutic Recreation" (A. Voight); "Instruction in Interpersonal Relationship Skills: An Evaluative Research Study" (R. Kunstler and D. Austin); "An Analysis of an Easter Seal Camp's Perceptions of Organizational Characteristics, Acceptance of Self, Acceptance of Others and Conflict Characteristics" (J. Glick); "Philosophical Basis for Therapeutic Recreation and Leisure Lifestyle Adjustment in Cardiac Rehabilitation" (G. Hayes and R. Antozzi); and "Leisure Counseling: A Component of Cardiac Rehabilitation and Heart Disease Intervention Programs" (T. Hoeft). (CL)

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EXETRA PERSPECTIVES

Concepts in Therapeutic Recreation

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EC160099

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TABLE OF CONTENTS

PREFACE vii

CHAPTER

1 Therapeutic Recreation Service: The Past And Challenging Present, H. Douglas Sessoms 1

2 Therapeutic Recreation In An Era Of Limits: A Crisis . . . A Challenge . . . An Opportunity, Kathleen J. Halberg 15

3 Living Up To The Name: Research Support For Therapeutic Recreation Service, Jesse T. Dixon and Daniel L. Dustin 31

4 The Formative Program Evaluation Procedure: An Internal Evaluation Tool For Therapeutic Recreation Services, Peg Connolly 41

5 Status Of The Therapeutic Recreation Professional: Unit Directors' Perceptions, Jeffrey P. Witman and Lou G. Powell 57

6 The Effects Of A Treatment Program For Chronic Pain Patients Using Relaxation Techniques, Enjoyable Imagery, And Biofeedback, Patrick J. Mckee 69

7 Some Uses Of The Multi-modal Model Of Curriculum Evaluation In Therapeutic Recreation, Christine Z. Howe 87

8 A Study To Dertermine The Educational Level And Practical Experience Of College Teachers In Therapeutic Recreation: 1980, S. Harold Smith and Robert W. McGowan 99

9 Systematic Curriculum Development, Steven C. Anderson and Helen A. Finch 109

10 Creativity: Strategies For Innovative Teaching And Parenting, Carol Stensrud 121

11 Attribution Theory In Therapeutic Recreation, Alison Voight 133

12 Instruction In Interpersonal Relationship Skills: An Evaluative Research Study, Robin Kunstler and David R. Austin 145

13 An Analysis Of An Easter Seal Camp's Perceptions Of Organizational Characteristics, Acceptance Of Self, Acceptance Of Others And Conflict Characteristics, Jeffrey Glick 153

14 Philosophical Basis For Therapeutic Recreation And Leisure Lifestyle Adjustment In Cardiac Rehabilitation, Gene A. Hayes and Robert K. Antozzi 175

15 Leisure Counseling: A Component Of Cardiac Rehabilitation And Heart Disease intervention Programs, Thea M. Hoeft 193

BIOGRAPHICAL SKETCHES 205

NAME INDEX 213

SUBJECT INDEX 217

PREFACE

The rights and needs of the disabled have been actively acknowledged and supported during the past several decades. This is especially true in the area of recreation and leisure services where a new awareness has resulted in the expansion and extension of services by government agencies, nonprofit organizations and commercial establishments. The growth of recreation and leisure services for the disabled has been assisted by the development of extensive undergraduate and graduate programs in colleges and universities across the United States and Canada. In general, these college and university programs have provided training opportunities for students and have advanced the body of knowledge related to therapeutic recreation.

EXETRA Perspectives: Concepts in Therapeutic Recreation has been initiated as a vehicle to assist educators, researchers, practitioners, and students in the dissemination of information pertinent to therapeutic recreation. EXETRA is an acronym for "Extended Education in Therapeutic Recreation Administration" and is a federally-funded, integrated curriculum design with doctoral-level therapeutic recreation specialists as the target population. One of the key objectives of Project EXETRA is the development, maintenance and dissemination of literature pertinent to therapeutic recreation. EXETRA Perspectives provides a forum for individuals wishing to present conceptual models, research findings, opinions, and new ideas in the areas of curriculum design, service delivery, philosophy, the effects of the leisure experience, and other professional issues and concerns related to recreation and leisure services for the disabled.

The fifteen (15) chapters presented in EXETRA Perspectives represent a wide cross section of topics and areas of interest from curriculum development to evaluation to techniques and process affecting the delivery of services. The chapters represent the work of students, educators and practitioners. Some of the chapters are representative of doctoral dissertation findings, while other chapters set forth the material offerred in presentations at selected regional workshops and gatherings. Still other chapters present new conceptual models and/or insights into the fu-

ture directions of therapeutic recreation. The content of each of the chapters is briefly outlined below.

H. Douglas Sessoms provides an overview of the historical development of therapeutic recreation services and presents his perceptions of the basic questions that should be addressed by therapeutic recreation professionals in Chapter 1, entitled "Therapeutic Recreation Service: The Past and Challenging Present". Sessoms reminds the reader that therapeutic recreation is a new profession with many challenges. He suggests that we have a unique mission directed toward the creation of leisure environments, both physical and attitudinal.

Chapter 2, "Therapeutic Recreation in an Era of Limits: A Crisis . . . A Challenge . . . An Opportunity," by Kathleen J. Halberg, suggests that the therapeutic recreation profes-sion is entering an era of unprecipitated challenges. This author suggests that we must reexamine and change a number of basic assumptions on which the profession has been built. She further maintains that, as we move toward decreased governmental influence, therapeutic recreators must develop creative approaches and solutions to critical problems and issues.

Jesse T. Dixon and Dan L. Dustin challenge the profession to examine recent research findings that support the claims of effectiveness by the therapeutic profession in Chapter 3. In their article, entitled "Living Up to the Name: Research Support for Therapeutic Recreation Service," these authors examine a leisure education intervention strategy in terms of its impact on the intrinsic motivation of mentally retarded children and adults. Further, they focus on the importance of outcomes of recreation participation for special populations in terms of self concept enhancement and independent participation. The implications of the research results of this chapter for practitioners are stressed.

Commenting on the need for the refinement and improvement of service delivery techniques and procedures, Peg Connolly presents a model for evaluation in Chapter 4, entitled "The Formative Program Evaluation Procedure: An Internal Evaluation Tool for Therapeutic Recreation Services." The chapter describes the structure and function of the Formative Program Evaluation Procedure (FPEP). This evaluation procedure involves seven (7) stages ranging from the initial description of the program intended for evalua-

tion to the revision of the program based on evaluation findings.

Jeffrey P. Witman and Lou G. Powell present the findings of a research study involving the perceptions of unit directors in state hospitals in Chapter 5. Their article, entitled the "Status of the Therapeutic Recreation Professional: Unit Directors' Perceptions," suggests that therapeutic recreation specialists rate above direct-care staff but below social workers, nurses and occupational therapists. This study also reports that there is a need for increased assessment and diagnostic/prescriptive skills.

Chapter 6, "The Effects of a Treatment Program for Chronic Pain Patients Using Relaxation Techniques, Enjoyable Imagery, and Biofeedback," by Patrick J. McKee, describes a study that examines the effectiveness of special relaxation exercises designed to relieve pain in patients who have experienced high levels of discomfort for more than one year. The treatment program studies used biofeedback-assisted deep relaxation techniques with enjoyable imagery. This research design involved pre- and post-test with control and experimental groups. Both the research procedures and findings advance the profession.

A model that can be used in curriculum evaluation in therapeutic recreation is presented in Chapter 7, entitled "Some Uses of the Multi-Modal Model of Curriculum Evaluation in Therapeutic Recreation," by Christine Z. Howe. Multi-modal evaluation is a triangulated or composite approach to evalution. This process of evaluation enables individuals to gather both quantitative and qualitative information about a curriculum design. Six (6) curriculum components that can be evaluated are discussed, including curriculum goals or competencies, curriculum content, curriculum organization, guidance and advising, instructional transactions and goal or competency achievement.

S. Harold Smith and Robert W. McGowan explore the backgrounds of individuals teaching therapeutic recreation in colleges and universities in the United States. Chapter 8, "A Study to Determine the Educational Level and Practical Experience of College Teachers in Therapeutic Recreation: 1980," presents the findings of this study. Questionnaires were completed by 66 individuals. It was found that the majority of individuals teaching therapeutic recreation hold the doctoral degree and have less than six (6) years of practical experience.

Chapter 9, "Systematic Curriculum Development," authored by Steven C. Anderson and Helen A. Finch, presents the findings of a study relative to curriculum design. The methodology of this study involved competency identification, use of the Delphi Technique to validate competencies, and finally, the use of a puissance measure to determine the difficulty level of each competency. The chapter also outlines a method for clustering and sequencing competencies.

What is it that differentiates the creative person from others? How can individuals be assisted to escape from habit and be encouraged to use their creative abilities? These and other questions are explored in Chapter 10, entitled "Creativity: Strategies for Innovative Teaching and Parenting", by Carol Stensrud. The author suggests that creativity can be encouraged in children with handicapping conditions. The chapter explores a number of strategies that can be employed toward this end.

How individuals perceive themselves and their behavior, and how they feel they are perceived by others, is the basis of Attribution Theory. Attribution Theory has to do with assigning causality of behavior to the qualities of a client, situational factors, and the implications of these for one's future behavior. The challenge to the therapeutic recreation specialist according to Alison Voight in Chapter 11, entitled "Attribution Theory in Therapeutic Recreation," is to develop positive dispositional "attributions" in their clients. This chapter explores the development of programs that can assist individuals in feeling good about themselves and instilling feelings of success due to the individual's effort.

Therapeutic recreation specialists are considered to be within the broader sphere of the human service professions. Robin Kunstler and David R. Austin in Chapter 12, entitled "Instruction in Interpersonal Relationship Skills: An Evaluative Research Study," point out the need for genuineness, empathy and respect between the professional and the client. This chapter reports the results of a study concerning classroom training and interpersonal relationship skills. It suggests that special attention must be paid to teaching students how to express and respond to anger and hostile feelings.

Chapter 13, "An Analysis of an Easter Seal Camp's Perceptions of Organizational Characteristics, Acceptance of Self, Acceptance of Others and Conflict Characteristics,"

by Jeffrey Glick, reports the findings of a research study involving a summer residential camp staff. This research investigation points out the need for educational and training development in order to provide quality services. Glick suggests that involvement in camp environment can contribute to staff members' perceptions of self-acceptance as well as the acceptance of others. Further, he notes that decision-making and communication skills, as well as skills of democratic living, are important in the camp setting.

The importance of one's leisure lifestyle as related to heart disease is the topic of Chapter 14, by Gene A. Hayes and Robert K. Antozzi, entitled "Philosophical Basis for Therapeutic Recreation and Leisure Lifestyle Adjustment in Cardiac Rehabilitation." These authors surveyed ten (10) leading cardiac rehabilitation programs to determine the use of therapeutic recreation personnel and leisure programming in the total rehabilitation process. They found that therapeutic recreation is a major concern in the cardiac rehabilitation process and the expertise of the profession can be used to assist the cardiac client to learn to live again through leisure play and recreation.

Thea M. Hoeft discusses the relationship of leisure counseling to cardiac rehabilitation in Chapter 15, "Leisure Counseling: A Component of Cardiac Rehabilitation and Heart Disease Intervention Programs." According to this author, leisure counseling is being used in cardiac rehabilitation programs to reduce risk factors associated with cardiovascular diseases. This chapter presents the ways in which leisure counseling can be used in various phases of the total cardiac rehabilitation process. Specifically discussed are the uses of leisure counseling in the acute phase, recovery and rehabilitation phase, discharge phase, and the outpatient phase.

A number of individuals contributed significantly to the development of EXETRA Perspectives. Assistance in the development of the format of the book was provided by H. Douglas Sessoms, University of North Carolina. Dr. Sessoms provided the editors with key insights into the formulation of strategies related to the thrust and content of the book. He also assisted in the review of early materials submitted. We appreciate Doug's advice and counsel.

S. Harold Smith, University of Wisconsin, Green Bay, was also instrumental in the review of materials submitted.

In addition, he assisted in the conceptualization of the format by serving as a sounding board for our ideas.

A number of graduate students at the University of Oregon have also been instrumental in the development of this book. Their interest, enthusiasm, and desire to improve sources of information in the area of therapeutic recreation, served to encourage the editors to pursue this endeavor vigorously. Whenever we were in doubt as to the viability and importance of this publication, their support renewed our interest in the project. We would like to thank Carol Donovan, Barbara Williams, Alison Voight, Chip Cannon, and Jeffrey Glick for their encouragement and support for this project. It was because of the concern expressed by these graduate students and the editors that this document, initially established as a forum for graduate-level research in therapeutic recreation, came into being.

The editors also wish to acknowledge the support of the University of Oregon Press for their efforts in the layout and printing of the document. In particular, Walt Parsons was instrumental in assisting in its publication. Last, and certainly most important, has been the work of Lisbeth Duncan. As is the case with many projects of this type, one person must assume major responsibility for typing, editing copy, and insuring consistency throughout the manuscript. Lisbeth has performed this task in an extremely professional, diligent and capable manner. The editors wish to thank Lisbeth for her quality commitment to this effort.

EXETRA Perspectives has been planned as an ongoing publication. This book is intended to be the first of a continuing series of monographs published at the Center of Leisure Studies, University of Oregon, focusing on research in the therapeutic recreation profession.

Larry L. Neal
Christopher R. Edginton
Eugene, Oregon
April, 1982

THERAPEUTIC RECREATION SERVICE: THE PAST AND CHALLENGING PRESENT

H. Douglas Sessoms*

Let me at the outset say that I am not a therapeutic recreation specialist, but I do have a strong concern about the discipline and its relationship to other aspects of the recreation profession. It is important to understand that as a profession, parks and recreation, much less therapeutic recreation, has never come to grips with the central issue of its existence: the issue of identity. Why are we involved in this business to begin with?

Let us start by going back approximately twenty-five years to the first hospital recreation institute that was held in North Carolina in 1953 and look at what the issues were then in light of what the issues are now, and if any changes have resulted in growth. Often there is a feeling that because things are changing, there is growth; but not all change is growth.

Thirty years ago North America was in the immediate post-war years of World War II. Those in the recreation profession were trying to catch up. They had been

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suppressed in a lot of ways because of the war and the Great Depression years; there was almost a bursting of "let's live again." Recreation services -- contemporary recreation services -- grew out of the "let's live again" philosophy. People were optimistic. They were looking to the good life. The assembly lines which had been producing war machinery were now producing consummerable goods -- items to be purchased, consumed and disposed of. There was a great deal of hope and a great deal of "let's get on with the business of living."

It was an interesting time, one in which recreation as a field was concerned with promoting activities. We were concerned with sports; we believed that participation was inherently good, that recreation needed no other justification. There was shock when Paul Haun, a very fine psychiatrist in the fifties who did much for our field, first said that play can be pathological; that, in itself, play is not necessarily good. It can be bad. He talked about playing Russian Roulette as an illustration of pathological play. If you win, you lose.

Identity was important, but to a lesser degree than the issue of gearing up for new areas of service such as hospital recreation. Our curricula were normally entitled Recreation Leadership -- not Administration, not Parks and Recreation Management, but Recreation Leadership. That says something about where our focus and our thinking was. There were two distinct theories about what recreation was all about -- two schools of thought concerning recreation. There were those that held that recreation was strictly diversionary. It was fun; it was something you did spontaneously for the joy of doing it. It was an end in itself. Then there were those who said, "Recreation is a means to an end. It is something you do to instill certain values.

It is something you do to promote growth. It is value-oriented and therefore you should select certain activities to promote certain kinds of results. It should prevent delinquency or aid in the rehabilitation process."

Varied Perspectives. There was a great deal of idealism and absolutism. People knew where they stood. There were those who said recreation was treatment, a therapy -- that it could be used to accomplish specific goals and objectives. The professional was to match activity with illness and treatment. Others held that recreation was activity -- an end it itself -- which, when allowed in the hospital, provided a continuity for life. The recreation professional was there only to provide the opportunity for recreation, not to intervene.

Hospital Conference Concerns

It is interesting to note a few quotes which come out of the report of one of our earlier hospital conferences reflecting where we were in 1955. Edith Ball said, "Recreation is a part of living and does not change because of the setting. Recreation is just as much a need of a person in a hospital as it is for a person in the community. Are we doing therapy with boys in a community who have not been able to relate to community patterns? Are we doing therapy then or are we providing them with the outlets that are important for enriched living?" Sound familiar? Robert Duke with the State Hospital in North Carolina said, "The patient knows the recreator is to help him enjoy his stay, give him diversion, keep his mind and body occupied, to help him have a good time." Although not credited here, another statement reflects the time: "Should we indulge in this concept of total pushing in which their activities are

guided and directed, or should recreation activity be a voluntary thing in terms of its prescriptions? Should one prescribe only for those that actually seek help and consciously come and seek it?" Paul Haun: "There is a good reason for the division of labor in the hospital. Every staff member does not do everybody else's job. We all have our roles to play and if we are able to define our roles with reasonable clarity and understand without hurt feelings those areas in which they overlap and how each can compliment and support the total mission of the hospital, it would bring many of these questions into much sharper focus. There are very real hazards in having everyone be a depth psychotherapist in the hospital."

Then there were those who spoke of the specific value of activity: "Emotional patients have the need for socialization; the need for activities which give a release of tension; the need to establish routines; the need for activities which provide opportunities to aid in keeping in touch with reality." To do this, they cited, "Bingo may be used as an opener. It should be adapted to enable more social interaction to take place . . . . Dramatics offer excellent possibilities for self-expression . . . . The development and functioning in small clubs provide opportunities for interpersonal relationships and the taking of responsibility . . . . Dance, particularly folk and modern, offer very good possibilities for interrelationships . . . Sports, finger painting on large sheets of paper, and rhythm bands are some activities which provide opportunities to release the tension."

You can see that at this conference, both schools of thought were being advocated. There were those that were talking about prescriptive activities; they knew that

certain activities -- at least they felt certain activities -- had specific benefits and outcomes. Others were saying, "Is recreation any different in the hospital than it is in the community? Is it not really an effort by the recreator to create, in this setting, opportunities for the recreation experience? Is recreation therapy or is it therapeutic?" The conflict was already developing.

The conclusion of that meeting and the conclusion of those persons who were involved with that process in the early fifties, was that hospital recreation was needed; that it had a value and was medically desireable; that it would require specialized training; but that recreation in a hospital setting was no different than was recreation in any setting. Also, that it was not therapy, per se, nor was it a specific set of activities, for only the participant knew when he had recreated. But some wanted more than that. They wanted to know, "How do you know when one is recreating?" It seems essential, if you are going to be a professional in the medical setting, that you measure the effects of the experience or you cannot justify your service. But, can we schedule and direct recreation? Of course not. We can describe the condition; the participant is the only one who knows what has happened, and sometimes he is unaware of the experience, except in retrospect. He knows he has entered an activity, but was it recreational?

Evolution of the Profession

Somehow we did not resolve the problem of definition. What we did was accommodate both views by focusing on the issues of professionalism. We continued the debate in the literature, but the profession began to emphasize such

things as certification, accreditation, and curriculum design. We also began to respond to the federal carrot. The Vocational Rehabilitation Administration came along in 1963 with grants for the training of recreation specialists to serve the ill and disabled, so we quit calling ourselves hospital or medical recreation, which was the label we had given ourselves in the fifties under the guise of the American Recreation Society's Section on Hospital Recreation. We started calling ourselves Recreation Specialists for the Ill and Disabled, because that's what the federal government wanted to support. Later the Bureau of the Education for the Handicapped entered the training-support area. It was concerned that recreation, of therapeutic value, had to occur for the disabled and ill, the handicapped in the community as well as in the institution. It took therapeutic recreation out of the hospital, but the need to demonstrate the value of the recreation experience in the medical setting remained.

A Role of Leadership. For a while the therapeutic recreation group grabbed hold of the leadership reins; and the park and recreation profession, in general, responded to their voice. Therapeutic recreation is not an abrasive notion. They could embrace the concept of recreation for special populations as being no different from recreation for anyone else. The therapeutic recreation specialist could create the opportunity for the recreational experience by removing architectural barriers, creating special kinds of centers for the sheltered, and trying to integrate the disabled into normal programming. The concept of therapeutic recreation meant that you were not trying to modify, shape or correct behavior, but that you were working to create opportunities for the recreative experience through

the elimination of barriers and other things which had prohibited it.

That concept seemed acceptable during the sixties and early seventies; then we began to experience economic hard times. The cost of medical care began to skyrocket, and those in the hospitals cried out to their fellow recreation professionals, "We can't survive with that definition. We have to demonstrate that ours is a therapy. We have to demonstrate that when a person comes to recreation therapy, what he receives is a part of his treatment, so the insurance companies will pay for it. Other therapists, such as occupational therapists, have the doctor write a prescription for their service -- why not recreation?" But can you prescribe the recreation experience? Can you predetermine from the outset that recreation is, in fact, going to give the patient a sense of relaxation, creativity, and so on? Or is recreation therapy just another activity with potential, pre-concluded results? Swimming may be physically active, but is it recreational?

Those therapeutic recreationists working in the institutional setting found themselves somewhat uncomfortable in their own profession and speciality. They were being asked to respond to a concept (therapeutic recreation) which wasn't going to get them many "brownie" points with their support system, the hospital administration. So they discovered (rediscovered) that concern of the movement which said that recreation was a means to an end, that it was goal-oriented from the very outset, that it could be a treatment modality. The challenge to the professional was to define what those goals were for the individual, then match the activity with those goals. The challenge was in activity analysis. Once that was accomplished, recreation could emerge as a therapy, as an intervention and treatment

tool. The assumption is that it can be done and that the recreative result will occur, that recreation is inherent in activity. But what about freedom of choice, the essential element of our definition of recreation?

Evolution or Confusion. Well, we have come full circle and are back to the central issue confronting the field: Is recreation treatment or therapy? Are therapeutic recreationists recreators or therapists? Those who subscribe to the notion that recreation is therapy have said that maybe they are not a part of the recreation profession; maybe they are a profession in their own right. Those who subscribe to the notion that recreation is recreation regardless of the setting continue to identify with the Recreation and Park movement. Some of them feel more comfortable with the term, "recreation for special populations," rather than "recreation therapy" or "therapeutic recreation." The question is where do we go now? Have we really changed in 25 years? Are we the same?

Well, changes have occurred even though the issue of who we are remains. Some of the changes that have occurred are, briefly mentioned:

- We no longer depend upon physicians to verify the importance of our activity.
- We have our own researchers and literature.
- We have established recreation curriculums and are moving forward with the process of accreditation.
- We have established a professional body, NRPA, with special interest groups such as NTRS.
- We have also developed our own language and techniques of operation.
- We have our own writers.

- We have our own journals.
- We no longer depend upon someone else to write for us -- we do that ourselves.

We have done, in a sense, what is required to become a profession -- except for one thing and that is to define our role, our reason for existence.

Guiding Questions. What is our basic role? What is our purpose? What is our reason for being? That remains the issue. Are we therapy? Are we recreation? Is recreation a means to an end, or is it an end in itself? Perhaps a way out of that dilemma, a way to define our role, is to look at the uniqueness of our service, of our profession. By talking about our uniqueness, our mission, we define our role, our separateness. Aristotle said that the way you define one species, one thing from another, is to talk about how it is different from everything else. You focus on the differences, not on the similarities. When you focus on similarities, you are talking about relationships, about the general or universal picture; when you talk about differences, you are defining the subject's uniqueness. What is the uniqueness of recreation? What gives us identity?

Our uniqueness is our concern for leisure, our concern for the recreative behavior of the public. Our mission is to provide opportunities and environments for people to enjoy, to experience the recreative moment. It requires us to create those opportunities and environments. No one else is given that responsibility -- no one else. It is what the public expects of us, and when we meet that expectation, the public provides the resources we need to do the job.

What do we perceive ourselves to be? Is it the same perception as those who mandate our presence? In the hospital is it the physician or is it the patient who asks for our services? Who gives us our reason for being at the hospital or the institution? To answer that, let us look at our mission in terms of what we are doing: What "evil" are we combatting? Like all other social service professionals, we need to be against something. The law is against injustice; social work is against poverty; medicine is against illness. What is recreation against? We are against boredom, the sameness of life. We are against boredom, for it is alien to the human spirit. It denies qualitative existence. We believe it is the mission of the Recreation and Park movement to create the potential for individuals to have the recreation experience.

Recreators -- Recreation Specialists. We are uniquely concerned about that element of human behavior known as the leisure expression. In order to enhance that expression, we direct our energies to create environments, both physical and attitudinal, which accompany and support the recreation act. We allow recreation to happen. In doing that, there are things that we do that make us somewhat like others, and therein is one of our problems. We teach activity skills, but we are not educators. We are not social workers, although we counsel. We are not therapists, although we are part of the healing process. We are not nurses, although we administer to the ill and disabled. We are not advocates, although we speak on behalf of the less fortunate. What are we? We are recreators. We work in many settings, including the medical setting, to accomplish our mission. We get in trouble when we step out of our role, when we become teachers; when we become social

workers; when we become psychiatrists; when we become therapists.

The Skills and Knowledge of a Therapeutic Recreation Specialist

Don't let my statements inhibit you, because to be a good recreator you need to be a good diagnostician. You need to do what other professionals do. You need to be able to diagnose what's going on in that leisure setting, or in that community, or in that institution, as it relates to that leisure experience, so you can make judgements about what might be done. You start out with a diagnosis.

You must also be an evaluator; you must be able to assess actions and programs in light of some goal, standard, or objective. You need to be able to design instruments which help you in the evaluation process, to help you know where people are and what they are doing and feeling.

You need to be a good listener; this is a basic skill in counseling. Learn to hear what people are telling you with their presence, body language, voice and emphasis.

We have to be good planners. We have to be good public relations people. We have to be good advocates. We have to be good resource people. We have to be good programmers. A lot of those tasks are tasks that other people do, but we are doing them as they relate to a specific set of concerns -- the leisure behaviors of the people we serve.

Sometimes in our effort to become good teachers, good diagnosticians, good evaluators, we get so involved in those things that we lose our perspective. We become so concerned about advocacy that we become more than an advocate for leisure concerns; we become an advocate for the individual, and suddenly find ourselves being cut off from our mission. We forget who we are. When we start doing

someone else's job, they respond by protecting their turf; they snipe at us, ask for our justification. What is our training in physiology and anatomy? How many laboratory experiences did we have in motor development? What are our credentials for counseling? How many hours did we have as a supervised therapist in order to be able to become a counselor?

A Caution. We can become so concerned about management by objectives, concerned with efficiency and effectiveness, that we forget about programming. We can become so concerned about the evaluative process that we fail to be effective in creating the recreation environment. We become concerned with the process, not the result, and that negatively affects our functioning. So we must maintain some sort of balance; we must recognize that all of these roles are roles that we and other professionals assume. But we differ from them as we apply these goals to our mission -- creating and maintaining opportunities for recreation. That is where we apply the skill of observation; that is where we apply our skill of programming.

Our Uniqueness. When we begin to focus on that mission, our uniqueness, and not try to be quasi-social workers, semi-psychiatrists, part-time physical therapists; when we start looking at our role as the provider of recreation opportunity, we find that role is uniquely ours. No one else is doing it. Occupational therapists (OT) are not doing our job. Physical therapists (PT) aren't doing our job. Psychiatrists are not doing it. Only we do it. When we start looking at our unique role, things fall in line. When we recognize that we are not therapy, but do provide the possibility for a therapeutic experience, we will have no difficulty with P.T., O.T. or Nursing. When

we recognize that the activities we provide may or may not be recreative, but that they have the potential for enhancing and enriching the individual spirit, then good things will happen to us. We will have resolved the philosophic dilemma which exists when we try to blend freedom of choice with predetermined results.

Our Challenge. We don't have to apologize for being recreators, for providing the recreation environment. That is what the public expects from us; and when we fall short of providing those opportunities, the public will turn us out. The public will not cease to play, but they may let somebody else provide those experiences, those environments, those settings. The need for the recreation experience is there. It is a question of our ability to respond to that need. It is our social mandate and a darn good one.

It is hoped that these comments will help clarify the issues of motivation and definition. It is also hoped that they will provide a framework for evaluation -- recognition that the objective of the recreator is to create and understand the recreation environment and the forces that impinge upon it. Once the role of the recreator is defined; once the mission of the recreator is determined; once the uniqueness of the recreator is established; the profession will be secured. Remember, we are uniquely concerned with recreation and leisure services. Nobody else can say that. No one.

Chapter 2

THERAPEUTIC RECREATION IN AN ERA OF LIMITS: A CRISIS . . . A CHALLENGE . . . AN OPPORTUNITY

Kathleen J. Halberg*

Introduction

Therapeutic recreation, and indeed the larger profession of recreation and leisure, as well as all human service professions, face unprecidented challenges in the 1980's. The current philosophy of the federal government, and what appears to be an even more significant change in the common attitudes of many people concerning the extent and delivery of human services, portend great changes within this decade. At the least, it appears that current financial resources will decrease, especially from the federal government; state and local funding for recreation leisure, upon which we have grown to depend, will be more tenuous; and increasing numbers of agencies and groups will find it necessary to pursue funding from alternative sources. Creative solutions will need to be found, and in

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some cases are being found, to meet these increasing challenges.

While creative approaches to the current situation are essential, it is equally important that the current era be kept in perspective. A profession does exert control over its own destiny; an era of limits can be a time of challenge and opportunity. Within this chapter, the implications of current social trends in society to the practice of therapeutic recreation will be discussed, and relationships to the future of the profession will be developed.

Current Social Trends

To state that the recreation and leisure field, and especially therapeutic recreation, is emerging as a profession is perhaps unnecessary. However, it is well to keep in mind that we are very young in comparison with many other professions and are still emerging and developing basic concepts, philosophies and research. Indeed, during the past decade the therapeutic recreation profession has been significantly influenced by the social movement of securing equal opportunity for all citizens. At least partially because of this trend, and the resultant laws and regulations, we have learned to become significantly more accountable in our professional practice. In addition, many therapeutic recreators have responded to the broader implication of equal opportunity for all by becoming advocates for and with individuals with disabilities.

A second social trend is occurring in this country which may well be viewed as a reaction to the trend toward equal opportunity, a trend toward decreased government influence and financial support in many aspects of living.

This trend, too, will significantly influence the therapeutic recreation profession.

Equal Opportunity for All

The social movement of securing equal opportunities for all citizens began in the mid-1950's. Ethnic minorities, women, the elderly, and individuals with disabilities have advocated for, and in most cases have obtained, legislation which mandates equal opportunity. None of this legislation was adopted without significant advocacy efforts by the groups involved. Indeed, people with disabilities found it necessary to "sit-in" in Washington, D.C., and San Francisco to obtain release of regulations for the implementation of the Rehabilitation Act of 1973.

Current significant legislation has been adopted which mandates equal opportunities for individuals with disabilities, as well as providing funding for therapeutic recreation preparation and demonstration programs. The two major acts, about which most therapeutic recreators are aware, are the Education for All Handicapped Children Act of 1975 and the Rehabilitation Act of 1973, especially Section 504 of that law. The Education for All Handicapped Children Act mandates a free, appropriate public education for all children in the least restrictive environment, which rather directly implies the mainstreaming of children with disabilities into the educational environment which is least restrictive to each individual. Therapeutic recreation services are included as a related service in this act. Section 504 of the Rehabilitation Act prohibits discrimination based upon a handicapping condition by an organization or agency receiving federal funds. This Section has

frequently been called the civil rights act of people with disabilities.

Other significant legislation, and regulations for the implementation of the legislation, have resulted from the trend toward equal opportunity for people with disabilities. This legislation was concerned with the quality of the environment and care in long-term care facilities, not only for the elderly, but also for individuals with developmental, physical, and emotional handicaps. Related to Medicare funding, large volumes of standards were developed concerning the environment of residential facilities and the quality of care in these facilities. Of particular concern to therapeutic recreators were program standards concerned with rehabilitation and activity programs.

In order to assure compliance with these program standards across the country and within individual states, significant documentation has been mandated. This has encouraged, indeed forced, therapeutic recreators and the profession to develop methods and tools for greater accountability. Participant assessment techniques and tools have been adapted from other fields, and many leisure assessment tools and techniques have been developed. Many therapeutic recreators have struggled with learning to develop appropriate and measurable objectives, and their use in professional practice is growing. We have learned to develop systematic program plans and to evaluate the effects of the program plans. Through these methods and techniques and other methodologies, the practice of therapeutic recreation has become considerably more accountable during the past decade. Indeed, the practice of therapeutic recreation has become significantly more precise and sophisticated, at least partially as a result of attempting to meet regulations and program standards.

This legislation alone has not, of course, guaranteed equal opportunity and participation, but the increasing emergence of individuals with disabilities into the mainstream of society is apparent. The concerns of people with disabilities are more frequently discussed in the news and are the subjects of motion pictures, television programs, books and articles. There would appear to be a greater awareness of individuals with disabilities in society generally and some of the issues with which they are concerned, as well as better-organized and more sophisticated service delivery systems.

Participation Not Equal to Expanded Awareness. While greater awareness and visibility has occurred, equal participation in the community by people with disabilities cannot be said to have been accomplished at this point in time. Hutchison and Lord (1979) have identified six issues which they suggest prevent involvement of individuals with disabilities in the community:

- Society's negative attitude toward differentness;
- Recreation and leisure seen as low priority;
- Recreation seen as therapy;
- Lack of support services for community involvement;
- Inadequate leadership and inappropriate programs; and
- Dead-end, segregated services (pp. 15-27).

The social trend toward equal opportunity, then, has not only resulted in the increased accountability of therapeutic recreation services, but the trend and the related issues raised by Hutchison and Lord have had other significant implications to the practice of therapeutic recreation which have, in some cases, altered the philosophy and practices of therapeutic recreators. Indeed, many therapeutic recreators have been forced to reexamine their

philosophy of professional practice, the ways in which they interact with people with disabilities, the goals and purposes of therapeutic recreation and the role of the therapeutic recreator in the mainstreaming process.

The Facilitator/Advocate. Reexamination here has been based upon the concept that people with disabilities have the right to participate in all opportunities, including leisure opportunities, which are available to all citizens. A major implication of this concept would appear to be that the therapeutic recreator, then, not only has a role in helping individuals with disabilities to function more effectively with greater satisfaction in typical leisure experiences, but she/he also has an important role in working with the community -- agencies within the community, staffs within agencies, and the general public -- in preparing the community and the services which it provides for the participation of people with disabilities. This has been termed the facilitator/advocate role.

The facilitator/advocate role appears to be different from the role traditionally assumed by many therapeutic recreators. Indeed, the perhaps more typical hierarchical therapist-client relationship may be antithetical to the facilitator/advocate role. Acceptance of the facilitator/advocate role implies that the therapeutic recreator and the person with a disability work together to facilitate leisure participation and that the person with a disability assumes a greater responsibility in meeting his/her leisure needs and in obtaining his/her leisure rights.

The social trend toward equal opportunities for all, including leisure opportunities for people with disabilities, then, has had significant implications for the practice of therapeutic recreation. We, as indiyidual

therapeutic recreators, as well as a profession, have become significantly more accountable for our professional practices and programs in response to legislation which has attempted to mandate equal opportunity. In addition, we have increasingly recognized that the facilitor/advocate role is essential to gaining true equal opportunity and participation in the community by people with disabilities.

Decreased Government Influence and Support

A more recent social trend, one which may well be in reaction to the social trend toward equal opportunity, is also particularly apparent today. In recent years, culminating in the most recent presidential election, citizens appear to be increasingly uncomfortable with the level of government control, and support for that control, of many aspects of living, especially support for the human services. People appear to be no longer willing to pay for what is perceived as an unnecessary level of regulation and service.

Deregulation. The current activities of the federal government reflect this latter social trend and are perhaps in the forefront of the trend. Deregulation has become a primary goal and is being rapidly pursued. Significant efforts are being made to eliminate federal regulations in a wide variety of areas with what appears to be particular emphasis upon the human service areas. The regulations which implement laws, some of which have been in effect for many years, are frequently being eliminated totally or rewritten with much narrower interpretations. Of special concern to people with disabilities and therapeutic recreators is deregulation in relationship to the Education for

All Handicapped Children Act and the Rehabilitation Act of 1973.

Decreases in funding to federal government agencies, especially those in the human service areas, and a reallocation of funds to lower levels of government are also reflective of the social trend toward decreased government control and support. Funding for the Department of Education, for example, has been severely decreased. This effects funding for therapeutic recreation through the Office of Special Education and Rehabilitative Services for preservice and inservice education programs and demonstration projects.

Back to Blocks . . . Basics That Is. Funding which has previously been controlled on the federal level will not be controlled on the state and local levels through block grants to states. It seems likely that this change, combined with the efforts toward deregulation, will result in inequities among states and within individual states in the provision of human services and especially services to individuals with disabilities.

Therefore, decreased financial support for the human services will be generally available, and that which is available will have to be competed for on the state and local levels. In addition, fewer regulations will govern the distribution of financial support. Within this new system, it seems likely that services to individuals with disabilities in education, for example, will receive substantially less financial and regulatory support than has been the case in recent years. In addition, it also seems likely that physical education, recreation and leisure services, including therapeutic recreation, will be among those most adversely affected by these changes.

Considering the more recent social trend toward decreased government influence and support, then, the therapeutic recreation profession finds itself with perhaps unprecedented challenges. To be sure, it is difficult in these uncertain times to remain confident in the future of equal opportunities and participation by individuals with disabilities.

These challenges appear to be particularly uncomfortable for two reasons. First, since we are in the midst of the social trend toward decreased government influence, we do not have the perspective of history. We cannot know, at this point in time, what sort of human services and human service delivery systems the public will be willing to support financially. We cannot know the balance between the extent of services and regulations and the willingness to support those services and regulations which will be comfortable for the majority of the people. It will be in the future that the issue of the level of the quality of living for all citizens in relationship to the need for government influence to assure that level of quality will be determined.

Secondly, the therapeutic recreation profession, as well as all human service professions, has received unprecedented regulatory and financial support from the federal government in recent years. While it has sometimes seemed difficult to meet the standards which have grown out of legislation, legislative and regulatory, as well as financial, support for the human services, including therapeutic recreation, has existed, and we have become accustomed to that high level of support. Perhaps human service professionals have grown to assume that the current level of support would continue and might well increase in the future. Taken from a narrower, more recent, perspective of

having had substantial support, the loss of this support seems overwhelming; but taken from a broader, historical perspective of not always having had such a high level of support, its potential loss may not be as devastating.

Therapeutic Recreation in an Era of Limits

What is the future of therapeutic recreation in an era of decreased government regulatory and financial support? How are we to respond to what appears to be an ever increasing need for services with ever decreasing resources to provide those services?

Based upon what has been discussed earlier (in this chapter), it appears to be critical that therapeutic recreators view the current situation from a broad perspective, rather than responding in a narrow and crisis-oriented manner. Times of difficulty are times of challenge -- and perhaps opportunity -- for they force reexamination and change.

The recent experience with Proposition 13 in California is perhaps helpful here. Dire predictions were made concerning the future of human services in the state, including recreation and leisure and therapeutic recreation services, should that ballot measure be adopted. While the full implications of Proposition 13 are yet to be felt in California, some of the results are apparent and are not all negative. Although times have been difficult, professionals were forced to reexamine what they had been doing, how services were being delivered and how services were being financially supported; and many creative alternatives have been found. These include increased cooperative efforts among agencies to provide services, eliminating what

had been in some cases a duplication of services; a reexamination of the role of some types of agencies, which are now moving in the direction of providing information and referral and consultation rather than direct services; contracting of services to other agencies and private firms; and a greater emphasis upon the use of volunteers and the families of participants to provide services. The public, including individuals with disabilities, continues to receive leisure services, sometimes in alternative ways. Although some decreases have occurred, there have been relatively few complaints from the public. The profession continues to function and remains alive and healthy in the state.

Perhaps this sort of uncomfortable reexamination process of what we have assumed to be "givens" does not occur unless the process is forced upon us by external forces and influences. The current trend toward decreased government regulatory and financial support certainly would appear to be one of those external forces which strongly encourages reexamination and creative alternatives.

Recent Strengths From Which to Draw. In a sense because of the influences upon therapeutic recreation of the social trend toward equal opportunity for all, the profession enters this era of limits in a relatively strong position. We have learned to become more accountable in the delivery of therapeutic recreation services, having begun to explore the tools, techniques and methods necessary for the measurement of the effects of therapeutic recreation programs upon individuals. We have begun to explore and develop the skills necessary to assume the facilitator/advocate role, learning to work with agencies in the community, government officials, and the public to accomplish

our goals. Both the ability to be accountable and the ability to advocate with government and the public will be critical competencies for any profession or group with specialized concerns as we enter this era of decreasing regulatory and financial support. If we are to obtain the necessary resources to continue to operate in a professional and sophisticated manner, from current, as well as alternative, sources, we must be able to be accountable for what we do and able to advocate in a wide variety of situations and with a wide variety of individuals for our programs and concerns.

In the area of professional activities, we also appear to be in a relatively strong position. Positive reexamination and activities are currently occurring which will strengthen the profession, stimulated primarily through the activities of the National Therapeutic Recreation Society. As many therapeutic recreators are aware, a major reexamination of philosophical alternatives within the profession is currently in process. Based upon a paper developed by Meyer (1980), which traces the historical roots and implications of philosophical alternative positions to the professionalization of therapeutic recreation, four philosophical alternatives have been developed which have been under active discussion by therapeutic recreators throughout the country during the past year (N.T.R.S., 1981). This sort of reexamination, and the potential for eventually arriving at a philosophical statement with which most therapeutic recreators can be reasonably comfortable, is, first of all, healthy for any profession. Perhaps more importantly in these times, however, such a statement will be of great assistance as it becomes necessary to represent the profession and its concerns in a broad range of situations with a variety of individuals.

National Support/Leadership. N.T.R.S. is also currently involved in a number of activities which will contribute to the continuing development of the profession. Accreditation standards for university curricula are being revised and upgraded, a new personnel credentialling program has been adopted, continuing education requirements are being developed, and work has begun to develop relationships, and eventually standards, for therapeutic recreation programs with widely respected accrediting bodies such as the Joint Commission on the Accreditation of Hospitals. Many of these issues are basic to the credibility and functioning of any profession, have a long history within our profession, and appear to be moving toward current resolution. The past few years have been significant ones in the history of the therapeutic recreation profession, but the next few years can be every bit as significant if we view them as a time of challenge and opportunity.

Summary

The therapeutic recreation profession finds itself in an era of perhaps unprecedented challenges. As a result of the social trend toward equal opportunity for all, including individuals with disabilities, we became accustomed to significant regulatory and financial support from the federal government. We now are in the midst of a second social trend of decreasing government influence and support, and it seems likely that the human services, including therapeutic recreation, will receive substantially less support from government on all levels.

It is essential that we view this period from a broad perspective. The profession, while relatively young and

emerging, has a rich history. In recent years, we have begun to develop the ability to be accountable in the delivery of therapeutic recreation services and the ability to advocate for our programs and concerns in a variety of situations. Current professional activities reflect significant growth and development.

Thus, we enter this era from a position of relative strength. Although the challenges will be severe in the next few years, such challenges can also provide the impetus for a reexamination of what have appeared to be basic assumptions, as painful as that process may be. Reexamination and change are most often uncomfortable, but they also have the potential to be ultimately healthy and growth-producing.

If we, as therapeutic recreators and as a profession, are able to view the current period broadly with open minds as a challenge and even an opportunity, this can be a significant era of growth and development for the profession. This can be an era of increasing unity within the profession, unity which is critical to our continuing growth and development.

The therapeutic recreation profession would appear to have at least three alternatives in this era of limits:

- We can function in a crisis-oriented manner, dashing from crisis to crisis as they occur, without a broad and unified perspective.
- We can continue to plod along, day after day, functioning as we have been functioning, quietly and desperately hoping that we will somehow survive.
- Or we can view this period as a time of challenges, oftentimes severe challenges, but challenges which

can provide the motivation for reexamination, continuing growth and development, and a coalescing into a stronger, more unified, profession.

An era of limits has the potential to be an era of opportunities.

List of References

Hutchinson, P. and Lord, J. Recreation Integration. Ottawa, Ontario: Leisurability Publications, 1979.

Meyer, L. E. Philosophical Alternatives and the Professionalization of Therapeutic Recreation. Arlington, Virginia: National Recreation and Park Association, 1980.

National Therapeutic Recreation Society. Alternate Positions and Their Implications to Professionalism. Arlington, Virginia: National Recreation and Park Association, 1981.

LIVING UP TO THE NAME: RESEARCH SUPPORT FOR THERAPEUTIC RECREATION SERVICE

Jesse T. Dixon*
Daniel L. Dustin**

Introduction

Therapeutic recreaton service has been described as programmed leisure activities for special populations which facilitate intrinsic motivation, result in a level of independent participation, and complement remedial treatment goals (O'Morrow, 1980; Gunn & Peterson, 1978; Kraus, 1978). As therapeutic recreation develops as an area of human service, there is a continuing need for research-based information to substantiate the claims inherent in that description. In other words, therapeutic recreation professionals need to illustrate objectively that they are, in fact, living up to their name.

The purpose of this chapter is to discuss recent research findings which support the use of therapeutic recreation service. Specifically, a leisure education intervention strategy is examined in terms of its impact on the intrinsic motivation of mentally retarded children and

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adults. The importance of leisure participation for special populations is investigated in relation to its effects on self-concept enhancement and the promotion of a higher level of independent participation. Also, the ways in which programmed leisure activities complement the remedial treatment goals of a program of speech and language therapy are analyzed. The chapter concludes with a discussion of the research's implications for program justification and funding.

Facilitating Intrinsic Motivation

When programming therapeutic recreation the specialist is challenged to select activities which motivate the client and, at the same time, meet the treatment goals of an agency. This is often difficult to accomplish. For example, an emphasis on the instructional goal of improvement in leisure participation may diminish a participant's arousal and performance. In such instances, the therapeutic recreation professional needs to establish a balance between recommending specific leisure activities to be taught due to their remedial value (e.g., fitness), and orienting the activity selection to the intrinsic motivation of the individual (Ellis, 1973). Ellis refers to the problem of striking such a balance as the "recreator's dilemma."

In three separate studies, Dixon (1981) sought solutions to this problem in the context of leisure education intervention strategies for moderately and severely retarded children and adults. By comparing different teaching methods for presenting a new leisure activity to his subjects, he was able to assess their effectiveness relative to the balance called for by Ellis. The research

results indicated that while all of the teaching methods led to improved performance, the method based upon activity analysis procedures led to a significantly higher level of performance. Moreover, the activity analysis approach did not impinge upon the subjects' enjoyment of their newly-discovered leisure pastime as evidenced by their verbal and visual expressions of approval.

In sum, Dixon's research suggests that a concern for objective improvement in leisure participation can be addressed without diminishing a client's enjoyment of an activity. The continuing challenge for practitioners and researchers alike is to identify intervention strategies in other therapeutic contexts which can be employed similarly. In so doing, the frequent conflict between treatment goals and intrinsic motivation can be avoided and the recreator's dilemma can be resolved.

Promoting Independent Participation

Of equal concern to the therapeutic recreation professional is the issue of promoting a client's independent leisure participation. To that end it is important to know just what it is about a particular leisure activity that makes it attractive or unattractive to the individual. With such information, the therapeutic recreation specialist is in a favorable position to intervene and facilitate a client's participation.

This issue has been studied in some depth relative to self-concept enhancement. For example, Luginbuhle, Crowe, and Kahan (1975) suggested that the status of an activity would be important to the promotion of a positive self-image. That is, successful participation in a leisure activity of high status would more likely lead to an

improved self-concept than would success in an activity of low status.

To test this hypothesis, Dixon (1979) manipulated the status, outcome, and attributions for selves and others when participating in a leisure activity. His findings indicated that the outcome from an activity was the determinant factor in enhancing a participant's self-concept rather than an activity's status. Stated differently, the particular leisure activity was not as important as being successful at some leisure activity.

This finding, coupled with Dixon's other work, clarifies the role which therapeutic recreation professionals can play in promoting a client's independent leisure participation. First, as exemplified by leisure education with mentally retarded individuals, the therapeutic recreation specialist can improve a client's outcome behaviors. And second, as illustrated in the context of attribution theory, successful outcome behaviors can positively affect a client's self-concept. If, as many human services professionals believe, an improved self-concept is instrumental to an individual's higher level of independent functioning, then it follows that the therapeutic recreation specialist plays a principal catalytic role in that process.

Complementing Remedial Treatment Goals

Building indirectly upon the work of Dixon, Dustin and Adams (1981) investigated the potential of programmed leisure activities to complement the remedial treatment goals of a program of speech and language therapy in an organized camp setting. Recognizing the importance of successful leisure participation to the enhancement of a

youngster's self-concept, and the importance of an enhanced self-concept to improved speech and language (Daly and Darnton, 1976), Dustin (1980) designed a three-tiered program of leisure activities at the University of Michigan Speech and Hearing Camp to engender successful leisure participation. The program consisted of activities which were intended to improve camper communication skills and stimulate lifelong leisure interests. Collectively, the programmed leisure activities served to promote feelings of confidence which then acted as a foundation for speech and language improvement (Dustin & Daly, 1978).

Dustin and Adams first studied the effectiveness of the Michigan program in the context of camper locus of control. Locus of control refers to the extent to which an individual sees himself as being controlled by external forces (i.e., "things happen to me") or internal forces (i.e., "I make things happen to me") (Nowicki & Strickland, 1973). Communicatively impaired youngsters typically view their condition as something that has been done to them and consequently as something that cannot be undone by them. Such a fatalistic perspective leads to poor self-images dominated by what Perkins (1965) calls the "loss of impact value." To reach their overall goal of improved speech and language, campers must realize that the source of improvement resides within themselves. That is, as a prerequisite to heightened feelings of self-esteem and more independent functioning, campers must believe in their own capability to effect change.

The results of the study indicated that the Michigan camp was successful in enabling youngsters to internalize a greater sense of control over their lives. An emphasis on leisure programming which allowed campers to influence

activity outcomes and experience success provides a logical accounting for their reported attitude change. The camp's program of leisure activities constituted one of the few areas where they could exercise complete control over their endeavors.

The fact that the campers made significant progress toward their principal therapeutic goals is testimony to the instrumental value of a more internalized locus of control. Apparently, youngsters who embark on a summer camp program with little appreciation of their own capabilities can begin to believe in themselves through such an experience. By enabling them to internalize a greater sense of control over their lives, organized camping can assist in cultivating the mind-set necessary to cope with their handicapping conditions.

In a second study, Adams and Dustin also examined the way in which a summer at the University of Michigan Speech and Hearing Camp affected the attitudes of its staff members toward their communicatively handicapped campers. The study was grounded in the belief that a helping professional's attitudes toward handicapped individuals can have a significant impact on the effectiveness of the therapeutic process (O'Morrow, 1980).

The investigation was a replication of work done by Austin and Lewko (1979) in another camp setting. They had suggested that the socio-recreational climate and informality of a camp environment can positively affect attitudes toward the handicapped on the part of those working with them. Adams and Dustin attempted to corroborate those findings and investigate further the extent to which staff roles might be associated differentially with attitudes toward handicapped individuals.

The results of the research supported the general conclusions of Austin and Lewko. The University of Michigan Speech and Hearing Camp did indeed promote more accepting attitudes in its staff members. Examination of the findings by staff role indicated further that counselors reported significantly more attitude change than did the camp's speech and language pathologists.

This finding suggests that it may not be organized camping per se that leads to more accepting attitudes toward handicapped individuals. Rather, it may be that a particular type of camper-staff interaction is the determinant factor. In this case, the counselor-camper interactions were of a substantially different kind than those involving the campers and speech and language pathologists. The informal socio-recreational context which formed the backdrop for counselor-camper interactions may have provided a motivational milieu for both parties. Such a milieu may have been absent in the more formal and structured relationships between the campers and speech and language pathologists.

With respect to complementing the camp's remedial treatment goals, this research indicates that the speech and language pathologists should take advantage of the relatively unique opportunity to interact with their communicatively handicapped campers beyond the bounds of therapy in the informal socio-recreational atmosphere of the camp community. Such interaction, while desirable for its own sake, is also desirable for its potential effect on their attitudes toward campers and ultimately for its probable effect on the quality of their therapy.

Summary

Collectively, these research results should make practitioners of therapeutic recreation service more confident of the intended services suggested by their professional title. Therapeutic recreation professionals can enable their clients to improve their participation in leisure activities while addressing intrinsic motivation. In addition, increased success in leisure activities can enhance the self-concept of clients and lead to a higher level of independent participation. Finally, leisure services offer a useful alternative approach for complementing remedial treatment goals in human service settings.

The findings reviewed here also contribute to an objective foundation of information which can be used to justify the existence and continued funding of therapeutic recreation programs. If human services are intended to improve clients' self-concepts, then funding decisions should be influenced by a program's effectiveness in motivating clients and improving their outcome behaviors. In that regard, therapeutic recreation services can provide just as many successful experiences as vocational and academic programs.

List of References

Adams, D. and Dustin, D. Camp Staff Roles and Attitudes toward the Handicapped. Manuscript submitted for publication, 1981.

Austin, D. and Lewko, J. "Modifying Attitudes Toward Handicapped Persons in a Camping Environment." Therapeutic Recreation Journal, Vol. 13, No. 3 (1979), 3-6.

Daly, D. and Darnton, S. "Intensive Fluency Shaping and Attitudinal Therapy With Stutterers: A Follow-up Study." Paper presented at the Annual Convention of the American Speech and Hearing Association, Houston, TX, 1976.

Dixon, J. "Leisure Activity Status, Outcome, and Causal Attribution: A Hypothesized Interaction Effect," Journal of Leisure Research, Vol. 11, No. 3 (1979), 182-195.

_____. "Research Update: Leisure Education Evaluated." Parks & Recreation, Vol. 16, No. 1 (1981), 16-17.

_____. Research for the Practitioner: Leisure Education and Activity Analysis With the Mentally Retarded. Manuscript submitted for publication, 1981.

_____. Comparing Teaching Methods in Therapeutic Recreation With Mentally Retarded Adults. Manuscript submitted for publication, 1981.

Dustin, D. "Shady Trails: Play That Coaxes the Speech-Impaired Child Into Society." Parks & Recreation, Vol. 15, No. 6 (1980), 37-38, 77.

_____ and Adams, D. "Enabling Campers to Take Charge of Their Lives." Camping Magazine, Vol. 53, No. 3 (1981), 23-24.

Ellis, M. Why People Play. Englewood Cliffs: Prentice-Hall, Inc., 1973.

Gunn, S. and Peterson, C. Therapeutic Recreation Program Design: Principles and Procedures. Englewood Cliffs: Prentice-Hall, Inc., 1978.

Kraus, R. Therapeutic Recreation Service: Principles and Practices. Philadelphia: W. B. Saunders Co., 1978.

Luginbuhle, J., Crowe, D., and Kahan, J. "Causal Attributions for Success and Failure," Journal of Personality and Social Psychology, Vol. 31, No. 1 (1975), 86-93.

Nowicki, S. and Strickland, B. "A Locus of Control Scale for Children," Journal of Consulting and Clinical Psychology, Vol. 40 (1973), 148-154.

O'Morrow, G. Therapeutic Recreation: A Helping Profession. 2nd Edition. Reston Publishing Co., 1980.

Perkins, W. "Stuttering: Some Common Denominators." New Directions in Stuttering. Edited by D. Barbara. Springfield, IL: Charles C. Thomas, 1965.

THE FORMATIVE PROGRAM EVALUATION PROCEDURE: AN INTERNAL EVALUATION TOOL FOR THERAPEUTIC RECREATION SERVICES

Peg Connolly*

Introduction

Therapeutic recreation is concerned with the provision of leisure services to special populations. Over the past fifteen years, this field has focused on advancing its professional status by emphasizing the refinement and improvement of service delivery techniques. The need for development of effective methods of program evaluation has been indicated frequently in the literature (Annand, 1977; Collingwood, 1979; Hillman, 1969; Kraus, 1973; Mitchell & Hillman, 1969; Nesbitt, 1969, 1970; O'Morrow, 1976). However, very little has been accomplished in the development of methods and procedures of therapeutic recreation program evaluation.

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The Formative Program Evaluation Procedure (FPEP) was designed specifically for use by therapeutic recreation practitioners for the internal evaluation of their service programs (Connolly, 1980). This procedure was developed based on the identification of evaluation concerns in the field of therapeutic recreation as found in a review of the literature and from conversations with practitioners from the field, as well as the investigator's personal experiences and expertise in both therapeutic recreation practice and program evaluation. Using a case study design, the procedure was field tested in four therapeutic recreation agencies between June and December, 1980. Results of the preliminary analysis of the procedure indicated that it is appropriate in terms of its relevance, feasibility and usefulness to the evaluation concerns in the field of therapeutic recreation. The purpose of this chapter is to describe the structure and function of the FPEP as an internal evaluation tool for therapeutic recreation services.

Program Evaluation in Therapeutic Recreation Services

In therapeutic recreation services, methods of program evaluation are perceived as a logical part of the programming process (Edginton & Hayes, 1976; Gunn & Peterson, 1978; Linford, 1971; Nesbitt, 1970; O'Morrow, 1976; Reynolds, 1976; Witt and Witt, 1970). Similarly, the responsibility for conducting program evaluations is designated to therapeutic recreators who plan and implement programs in the field setting. The FPEP was designed specifically for the evaluation of therapeutic recreation programs. This procedure is designed to be used by the internal evaluator or the therapeutic recreator who is

responsible for the provision of program services. The purpose of the procedure is to describe the program plan, document program operations, and analyze program goals and outcomes in order to make decisions about revisions and improvement of the evaluated program.

The proposed procedure is designed specifically for the evaluation of therapeutic recreation service programs. A program is defined as a specific set of activities and interactions designed for a particular purpose or need, and directed towards the accomplishment of a predetermined goal or set of goals (Gunn & Peterson, 1978). The comprehensive service program of an agency or unit is composed of a number of specific programs, each of which is designed, implemented, and evaluated independently of other programs. The FPEP is designed for use with specific programs rather than comprehensive agency programs.

Assumptions. The following assumptions relate to the nature of therapeutic recreation service programs. Before the Formative Program Evaluation Procedure is applied, these underlying program assumptions must be met:

1. Programs are composed of a specific set of activities and interactions designed for a particular purpose or need, and directed toward the accomplishment of a predetermined goal or set of goals.
2. Program goals are derived, based on perceived or identified client needs in relation to the therapeutic recreation service delivery purpose.
3. Program goals are directed toward change in client behaviors, i.e., improvement of behavioral functioning or the acquisition of leisure knowledge, skills and attitudes.
4. Clients are assigned to particular programs when their individual needs match the intent of program goals.

5. There may be a variety of plausible programming strategies available for accomplishing a particular set of program goals.
6. There are limited resources and time available for delivering program services.

If a program selected for evaluation does not meet the preceding assumptions, then the proposed FPEP may not be an appropriate strategy for evaluating such a program.

A Caution. One final notion held about programs in the development of the FPEP is that no program is perfect or without potential for further improvement. Thus, the use of the FPEP does not yield overall judgments on program worth, but assumes all programs have strong points and weak points. Therefore, the outcome of evaluation with the FPEP is an indentification of program strengths and weaknesses leading to implications for revision improvements.

Description of the Formative Program Evaluation Procedure (FPEP) Stages

The FPEP represents a descriptive evaluation approach focused on the collection of information that may be used in the revision and improvement of a service program. The FPEP combines elements from professional judgment models, congruence between objectives and performance models (Gardner, 1977), and utilization-focused models (Patton, 1978) of program evaluation. Howe (1978) recommends the systematic combination of evaluation model elements of a comprehensive and composite way to evaluate programs.

The FPEP has been developed with a simplistic evaluation design. The procedure is designed to yield descriptive information for program revision and improvement,

through the application of qualitative and simple quantitative methodologies. A high degree of sophisticated measurement and analysis is not required.

Practices, Procedures and Outcomes. Figure 1 depicts the evaluation concerns and program areas addressed in the FPEP. The concerns for program evaluation in the field seem to focus on the need for both the identification of program practices and procedures, as well as documentation of client outcomes (Cappel, 1974; Gunn & Peterson, 1978; Hoffman & Ely, 1973; O'Morrow, 1976; Witt & Witt, 1970). The FPEP incorporates an emphasis on program implementation in order to focus on procedures and practices utilized to implement the service program, as well as a documentation of client performance. The first component of the FPEP involves description of the program plan as suggested in the standards recommended by the Joint Commission on Standards for Educational Evaluation (1977). Each program area indicated in the FPEP addresses a specific evaluation concern through the examination of related program elements or variables.

The flowchart of the stages involved in the FPEP appears in Figure 2. The seven stages presented represent the complete evaluation process ranging from the initial description of the program intended for evaluation through the revision of the program based on the evaluation findings. Each stage is described in the following paragraphs.

Stage 1.0 involves the comprehensive description of the program plan, including descriptions of the following: program service function and purpose, goals and objectives, client population characteristics, program content and processes, program resources, and staffing requirements. A series of questions and sub-questions have been developed

Area of the Program to be Evaluated	Purpose of Evaluation	Primary Evaluation Concern	Program Elements or Variables to be Examined	Instrumentation
1.0 Program Plan	To describe the intended program and its related plan of action.	What is the program designed to accomplish and how will the program be operationalized for implementation?	• program service function and purpose • program goals and objectives • client population characteristics • program content • program process • program resources • staffing required	PROGRAM PLAN DESCRIPTION FORM SESSION DESCRIPTION FORM CLIENT PROFILE FORM
2.0 Program Implementation	To document the actual program activities and operations that occur in day-to-day implementation of the program.	How does the program function during actual implementation?	• program content • program process • program resources • nature of client involvement • unanticipated events and outcomes	POST-SESSION REPORT FORM
3.0 Program Outcomes	To describe anticipated and unanticipated client outcomes in relation to program goals.	What are the client outcomes of the program?	• anticipated client outcomes • unanticipated client outcomes • program goals	CLIENT PERFORMANCE DOCUMENTATION FORM

Fig. 1--Evaluation Concerns and Program Areas Addressed in the Proposed Formative Program Evaluation Procedure

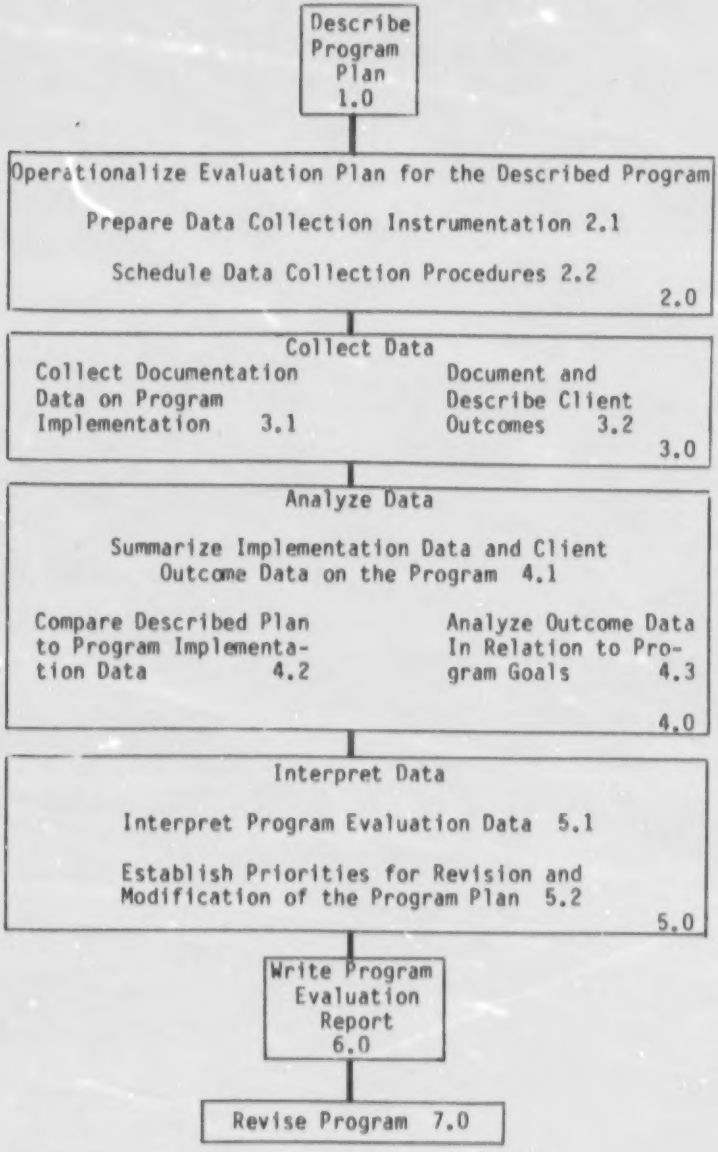
Describe Program Plan 1.0
Operationalize Evaluation Plan for the Described Program
Prepare Data Collection Instrumentation 2.1
Schedule Data Collection Procedures 2.2
2.0
Collect Data
Collect Documentation Data on Program Implementation 3.1
Document and Describe Client Outcomes 3.2
3.0
Analyze Data
Summarize Implementation Data and Client Outcome Data on the Program 4.1
Compare Described Plan to Program Implementation Data 4.2
Analyze Outcome Data In Relation to Program Goals 4.3
4.0
Interpret Data
Interpret Program Evaluation Data 5.1
Establish Priorities for Revision and Modification of the Program Plan 5.2
5.0
Write Program Evaluation Report 6.0
Revise Program 7.0

Fig. 2.--The Proposed Formative Program Evaluation Procedure: Flowchart of the Procedure Stages

to address the issue of describing the program plan and are incorporated into three instruments as shown in Figure 1. The instruments are designed to collect both qualitative and quantitative data about the program plan. These instruments were developed as the primary source of information about the program design plan prior to evaluation.

Stage 2.0 of the FPEP involves the operationalization of an evaluation plan for the described program. The intent of this stage is to prepare the plan of action for the actual collection of evaluation information. Instrumentation is prepared for data collection and a schedule is established for the collection of evaluation information on both program implementation and program outcomes. Two instruments have been developed for the documentation of program implementation and the description of program outcomes: the POST-SESSION REPORT FORM and the CLIENT PERFORMANCE DOCUMENTATION FORMS. These instruments are used throughout the implemention of the program to collect evaluative information about program activities and outcomes on a session-by-session basis. The instruments are designed to be completed by the internal evaluator based on observations and professional judgments regarding individual sessions, events and outcomes.

Stage 3.0 involves the actual collection of data on both program implementation and program outcomes. This stage continues throughout the entire program implementation period. Evaluative information is documented by the internal evaluator at the conclusion of each program session through the use of the POST-SESSION REPORT FORM and the CLIENT PERFORMANCE DOCUMENTATION FORMS.

In Stage 4.0 program evaluation data is summarized and analyzed. First, evaluation information is summarized in relation to the area of the program evaluated and in terms

of the program elements or variables examined within each of the three program areas, i.e., the program plan, the program implementation, and the program outcomes (see Figure 1).

In analyzing the program plan description, the following program elements or variables are examined: program service purpose and function, program goals and objectives, program content, program process, program resources, and program staffing requirements. The information on these program elements is summarized and content-analyzed directly from the designated instrumentation for this program area.

Analysis of program implementation is completed by summarizing evaluation data from the POST-SESSION REPORT FORMS on the following program elements:

- program content
- program process
- program resources
- nature of clients
- staff involvement

Evaluation data is summarized from all program sessions. Evaluation data on program modifications is grouped and analyzed in terms of its relation to program intent in order to identify discrepancies between the program plan and actual program implementation results. These modifications are content analyzed based on professional judgments of the internal evaluator and in terms of both the content of the modification and the recorded rationale for the modification.

The POST-SESSION REPORT FORM used to collect data on program implementation was designed to incorporate both quantitative data, in the form of likert scale ratings and yes/no responses, and qualitative data in the form of

descriptive observation notes related to the quantitative ratings. On the POST-SESSION ANALYSIS FORM, the quantitative ratings for each evaluation question from the POST-SESSION REPORT FORM are summarized over all program sessions and average ratings generated for each program element evaluated. The qualitative data is summarized in table form by program element over all program sessions. The quantitative and qualitative data are then analyzed in terms of the relative worth of overall average ratings combined with content analysis of descriptive observational notes within each program element.

Finally, the program outcome area includes analysis of program outcomes and client performance levels by examining the following program elements: anticipated client outcomes, unanticipated client outcomes, and program goals. Three analysis procedures are utilized to prepare this area of program evaluation data for interpretation. First, client performance data is summarized for the program in terms of the level of client gains related to the level of client exposure to program objectives (i.e., number of performance ratings indicating client attainment of program objectives in relation to the number of sessions or trials addressing the respective objective in which the client participated). This summarized performance data is then analyzed in relation to:

- the number of clients accomplishing program objectives,
- overall summaries of individual client gains on all program objectives, including a summary of unanticipated outcomes, and
- analysis of planned goals and objectives in relation to both program outcomes and individual client gains.

All three areas of the program are treated separately in terms of the summary and analysis of evaluation data. Generally, the data is grouped and reduced within the program elements examined for each program area. The overall purpose of this analysis stage is to summarize the evaluation data, identify discrepancies between the program plan and the actual program operations, and to examine any unplanned or unanticipated program adaptations and/or outcomes that occurred during program operations. At this stage of the FPEP, evaluation data is ready for interpretation.

In Stage 5.0 evaluation data is interpreted. Patton (1978) recommends that data analysis and data interpretation be conducted separately in order to allow for independent interpretations of the evaluative findings. The internal evaluator may wish to have other agency personnel or professionals at other facilities examine the analyzed data. By separating analysis and interpretation activities, these external professionals may make independent interpretations of the analyzed data without contamination of the internal evaluator's interpretations.

The primary purpose of the interpretation stage is to identify program strengths and weaknesses of the three program areas evaluated in the Formative Program Evaluation Procedure. Interpretations of the summarized and analyzed evaluation data are made in relation to the primary evaluation concerns (see Figure 1) established for each program area and becomes the basis for interpretation by the internal evaluator.

After strengths and weaknesses of the three program areas are interpreted, an overall interpretation of the total program is summarized. Based on this overall summary of program strengths and weaknesses, the internal evaluator

establishes priorities for the revision and modification of the evaluated program. Priorities are delineated based on professional judgments of the evaluator and include designation of revision concerns related to one of the three program areas. These revised priorities should be directed toward the improvement of the evaluated program and provide an indication of how the program may be refined when and if it is repeated in the future.

Stage 6.0 of the FPEP involves the preparation of the program evaluation report. This document should describe the summary and results of all evaluation activities and findings as completed in Stages 1.0 through 5.0.

The final stage of the proposed procedure involves the revision of the evaluated program. In Stage 7.0, the program is revised based on the evaluation findings and a new program plan is developed for future implementation of the program.

Limitations of the FPEP

The first limitation of the proposed Formative Program Evaluation Procedure relates to its level of development. The FPEP has been subjected to a preliminary analysis in the field setting; however, further development and testing will be required before the procedure is refined.

Another limitation relates to its designation of the role of internal evaluator. This internal evaluator role has not been addressed adequately in the evaluation literature. However, in the field of therapeutic recreation, internal personnel are responsible for program planning, implementation and evaluation (Gunn & Peterson, 1978; Nesbitt, 1970; O'Morrow, 1976). While the literature in the field of therapeutic recreation supports the role of

internal evaluator, there are some limitations related to the lack of expertise of practitioners in methods and procedures of evaluation, as well as the nature of analysis and interpretation required in the procedure.

A final limitation relates to the application of FPEP in the field setting and the use of evaluation results from the procedure. The FPEP yields descriptive information about the strengths and weaknesses of the evaluated program. These descriptive results are summarized from the internal evaluator's observations and professional judgments. Thus, the level of external validity is low. The implication of low external validity with the FPEP is that evaluation results from one evaluated program are not generalizable to other therapeutic recreation programs. Furthermore, since the procedure is based on the use of this descriptive evaluation approach, causal inferences regarding the relationship of program treatment to program effect or outcomes should not be made. The purpose of the FPEP is to describe and document the program, not to interpret cause, explain relationships, or to make predictions based on the results derived from the evaluation findings.

Summary

The FPEP was developed for use by therapeutic recreation practitioners for the internal evaluation of their service programs. The FPEP is based on a descriptive evaluation approach and directed toward identifying program strengths and weaknesses in order to improve the program. The proposed procedure incorporates the evaluation of three program areas: the program design plan, program implementation, and program outcomes. Seven stages are implemented to complete the Formative Program Evaluation Procedure from

the initial description of the program intended for evaluation through the revision of the program based on evaluation findings.

List of References

Annand, V. S. "A Review of Evaluation in Therapeutic Recreation." Therapeutic Recreation Journal, Vol. 11, No. 2 (1977), 42-46.

Cappel, M. L. "Providing Community Recreation Services to Special Populations." Therapeutic Recreation Journal, Vol. 8, No. 2 (1974), 72-78.

Collingwood, T. R. "Report on the Training Conference on Therapeutic Recreation Within Rehabilitation." Therapeutic Recreation Journal, Vol. 5, No. 2 (1971), 88-91.

Connolly, M. L. "Analysis of a Formative Program Evaluation Procedure for Therapeutic Recreation Services." Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign, 1981.

Edginton, C. R. and Hayes, G. A. "Using Performance Objectives in the Delivery of Therapeutic Recreation Service." Leisurability, Vol. 3, No. 4 (1976), 20-26.

Gardner, D. E. "Five Evaluation Frameworks," Journal of Higher Education, Vol. 48 (1977), 571-593.

Gunn, S. L. and Peterson, C. A. Therapeutic Recreation Program Design: Principles and Procedures. Englewood Cliffs, NJ: Prentice-Hall, 1978.

Hillman, W. A. "Federal Support of Recreation Services Related to Mental Retardation." Therapeutic Recreation Journal, Vol. 3, No. 3 (1969), 6-11.

Hoffman, C. A. and Ely, B. D. "Providing Recreation Counseling in a Psychiatric Hospital: A Vital Community Link." Therapeutic Recreation Journal, Vol. 7, No. 3 (1973), 3-7.

Howe, C. A. "The Development and Evaluation of a Model for the Evaluation of Master's Degree Curricula in Therapeutic Recreation." Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign, 1978.

Joint Committee on Standards for Educational Evaluation. Standards for Education Evaluation. Draft of manuscript under preparation for publication, 1977.

Kraus, R. Therapeutic Recreation Services: Principles and Practices. Philadelphia, PA: W. B. Saunders Co., 1973.

Linford, A. G. "A Criterion-referenced Approach to Program Evaluation in Therapeutic Recreation Service." Therapeutic Recreation Journal, Vol. 5, No. 2 (1971), 54-56.

Mitchell, H. J. and Hillman, W. A. "The Municipal Recreation Department and Recreation Services for the Mentally Retarded." Therapeutic Recreation Journal, Vol. 3, No. 4 (1969), 32-39.

Nesbitt, J. A. "Training and Research in Therapeutic Recreation Service for Handicapped Children: A New Era Begins." Therapeutic Recreation Journal, Vol 3, No. 2 (1969), 3-9.

_____. "Handicapped Child: Therapeutic Recreation Needs in Program Manpower and Research." Therapeutic Recreation Journal, Vol 4, No. 2 (1970), 33-40.

O'Morrow, G. S. Therapeutic Recreation: A Helping Profession. Reston, VA: Reston Publishing Co., Inc., 1976.

Patton, M. Q. Utilization-focused Evaluation. Beverly Hills, CA: Sage Publications, 1978.

Reynolds, R. P. "The Case Study Technique in In-service Training." Leisurability, Vol. 3, No. 2 (1976), 8-14.

Witt, J. E. and Witt, P. A. "Planning and Evaluation of Recreational Activities in Therapeutic Settings." Therapeutic Recreation Journal, Vol. 4, No. 4 (1970), 5-7, 35, 37.

STATUS OF THE THERAPEUTIC RECREATION PROFESSIONAL: UNIT DIRECTORS' PERCEPTIONS

Jeffrey P. Witman*
Lou G. Powell**

Introduction

There are times in the lives of many individuals working in therapeutic recreation when levels of patience are stretched to the utmost. These trials often occur when, in meeting someone, we share the line of work we're in. Having heard that we're recreational therapists, typical questions follow:

- Is that like Special Olympics?
- Is that part of occupational therapy?
- Is it volunteer work?
- Do you go to school for that?
- You're a what?

Initial interpretations of what therapeutic recreation is and what we do on our jobs can lead to a variety of trying follow-up queries including:

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- You've got a lot of patience, haven't you?
- You get paid for doing that?
- Is it tax-supported?
- Nobody helps me with my recreation!

Professional Awareness. Individuals who have worked in therapeutic recreation can probably relate to and add personal variations of the above statements. One can rationalize that such experiences are not atypical to new professionals and therefore must be tolerated. However, the possibility that there exists a lack of awareness of therapeutic recreation among medical and allied health professionals is a concern that cannot be ignored. The implications of these individuals not being well informed about our profession are far-reaching. For example, with rehabilitation and education budgets diminishing, a professional's relevancy to an agency must be clearly understood. As Park (1981) states relative to therapeutic recreation:

> The impact of (budget cuts) on professions such as ours will be an even increased demand for accountability. We will need to better define who we are, what we do and what are the expected outcomes. We will need to assure that all of us become more competent at doing what we say we do. And most importantly, we will have to more clearly demonstrate that what we do does, in fact, contribute to the care, growth, treatment, rehabilitation or education of the people we serve. In the final analysis, limited resources will go to those services that can clearly demonstrate their value and necessity (p. 13).

Unit Directors. State hospital unit directors are one group of professionals whose clear understanding of therapeutic recreation is critical. The departmentalization of state hospitals and training centers throughout the country has brought increased levels of management and programmatic responsibility to unit staff and in particular to unit

directors. Analogous to school principals, unit directors often set the directions of the unit's treatment thrust. Their perceptions of the relative importance of various disciplines and treatment modalities can shape the roles and functions of professionals on their units.

The following study was conducted to determine unit directors' perceptions of the therapeutic recreation professional. In addition to a summary of the procedures and findings of the study, implications for curricula and professional society activities are suggested.

The Study

Population. The population of unit directors at state hospitals in Northern New England (Maine, Massachusetts, New Hampshire, Vermont) was obtained through a telephone survey of mental health and state personnel offices in the region. A total of ninety-six (96) unit directors were identified.

Pilot Study. Fifteen (15) of these unit directors were involved in a pilot study designed to provide some insight into their perceptions of status. Specifically, they were asked to identify factors which determined status on their units and factors needed to enhance the status of the various professionals on their units. The information was used to develop the questionnaire survey for the main study.

Main Study. The questionnaire survey was then mailed to a random sample of fifty (50) unit directors. In completing the survey they:

- listed their educational background and years of experience in present position;
- ranked the comparative status of five job titles (direct care staff, nurse, occupational therapist, social worker) on their units;

- rated the need for a variety of status enhancers (competencies, skills, activities) among recreation personnel on their units;
- described the educational background and current roles of recreation personnel on their units;
- listed their perceptions of the factors denying recreation personnel full professional status and prestige.

Findings

Thirty-seven (37) unit directors (74% of the sample) responded to the survey. Both mental health and mental retardation facilities were represented. Respondents' educational backgrounds were most often in the areas of education, psychology, medicine and social work. The majority had two to five years experience in their current positions. Salient findings regarding their perceptions of therapeutic recreation personnel and programs include the following:

- Recreational therapists were rated above direct-care staff but below social workers, nurses and occupational therapists in rankings of the comparative status of unit personnel (Table 1 provides a summary of these rankings).
- Improved assessment and diagnostic/prescriptive skills and more technical knowledge regarding clients were most often mentioned as needed competencies for enhanced status of recreational personnel. (Table 2 provides a listing of the factors most often cited as substantial or critical needs.)
- The majority of recreational personnel did not have degrees in therapeutic recreation and were not performing some of the primary functions of an interdisciplinary team member (e.g., performing assessments, independently writing/signing progress notes, getting involved with discharge planning).

TABLE 1

Unit Directors' Rankings of the Comparative Status of Selected Personnel

Job Title	Average Ranking*	
	Mean	Mode
Social Worker	2.0	1
Nurse	2.1	2
Occupational Therapist	2.4	3
Recreational Therapist	3.9	4
Direct Care Staff	4.9	5

N = 32

* Measurement used was a Likert Scale from 1 to 5. A rating of 1 = highest status and 5 = lowest status.

TABLE 2

Unit Directors' Perceptions of Factors Needed to Enhance the Status of Recreation Personnel

Factors	N	%
Improved assessment and diagnostic/prescriptive skills	24	70.6
More technical knowledge regarding clients	23	67.6
More in-service training of fellow staff regarding role/benefits of recreation	22	64.7
More recreation personnel	22	64.7
Better planning/administrative skills	19	55.9
Better record keeping/evaluation/documentation	18	52.9
More extensive facilities/more space	14	41.2
Certification/licensing	11	32.4
More competence in therapeutic techniques (e.g., counseling skills, behavior modification)	8	23.6
Greater political acumen/advocacy skills	6	17.6

N = 34

Unit directors also listed their perceptions of the function of therapeutic recreation in the rehabilitation process. General statements predominated but, as Table 3 indicates, there were some specific functions identified. Social motor and leisure skill development were most often mentioned.

TABLE 3

Unit Directors' Perceptions of the Functions of Therapeutic Recreation in the Rehabilitation Process

Functions	Respondents	
	N	%
Social and interpersonal skill development	11	36.7
Physical and motor skill development	10	33.3
Leisure skill development	8	26.7
Preparation for and awareness of community	6	20.0
Allows for self-expression	6	20.0
Increases range of experiences	5	16.7
Provides group activities	4	13.3
Provides enjoyment/fun	4	13.3
Teaches use of leisure time	4	13.3
Builds confidence/self-esteem	3	10.0
Provides activity for clients with little to do	3	10.0
Supports other therapies	3	10.0
Contributes to team process	2	6.7
Provides break from routine	2	6.7
Provides evaluation/assessment data	2	6.7
Provides reality orientation	1	3.3
A.D.L. (activities of daily living) skill development	1	3.3

N = 30

Additionally unit directors provided their perceptions of the factors denying recreation personnel full professional status and prestige. Their perceptions can be

summarized in the following five concerns, each of which was mentioned by about one-third of the respondents:

1. Low Pay and Low Qualification Standards

   As one unit director expressed it, "Because of the salary schedule we can't attract many good people and we can't keep the good people we do get." Another commented upon "the lack of awareness of these positions among D. M. H. (State Department of Mental Health) officialdom."

2. The Perception that Anyone Can Provide Recreational Therapy

   As one unit director expressed it, "When the R. T. is on vacation, others step in and provide programs, with no loss of quality." Another surmised, "All of us, as a normal part of our lives, get involved in recreation so it's hard to see it as a speciality."

3. The Perception that Recreational Therapy is Fun and Games, Irrelevant to Enhancement of Skills and Client Development

   "I think the approach is too program-oriented and not enough clinical -- individualized -- adaptive", as one unit director stated it. Another said, "There's limited staff understanding of their (recreation therapist) functions and envy because they have it easy and are getting paid for having a good time."

4. Lack of Knowledge Regarding Clients

   As one unit director phrased it, "They lack the basic jargon of etiology and prescriptive techniques associated with our clients." Similarly, another suggested "They don't understand the social, behavioral, and/or psychological implications of disability.

5. Lack of Involvement in the Team Process

Two dimensions of this were expressed. One dimension was the failure of recreation personnel to fully participate in the team process "because they serve two masters -- myself (unit director) and the centralized recreation director." The other dimension related to the "lack of appropriate assessment skills and therapeutic techniques to really contribute to the team. We don't really care about bowling scores," stated one of the unit directors.

Implications

These findings suggest several primary needs relative to training and professional society activities in therapeutic recreation including:

- Curricula which develop competence in the nature and treatment of various disabilities;
- Political advocacy toward tightened job standards and higher pay;
- Quantitative and qualitative improvements of the print and nonprint media available to interpret the field of therapeutic recreation to others; and
- Advocacy for involvement in treatment teams coupled with curricula which develop the requisite skills to fully participate.

The need for strong professional association, more standardized curricula and relevant in-service and continuing education opportunities can be inferred from the list above.

Packard (1959), in his classic study of status in America, determined the six main bases our society uses in assigning prestige to an occupation:

1. The importance of the task performed.
2. The authority and responsibility inherent in the job.
3. The specialized knowledge required.
4. The brains required.
5. The dignity of the job.
6. The financial rewards of the occupation (pp. 80-85).

The opinions expressed in this study suggest that unit directors perceive therapeutic recreation personnel to be somewhat deficient in all of these criteria.

Limitations/Conclusions/Recommendations

Aside from the obvious limitations of geographic scope and sample size, the study is restricted by the narrow perspective of status and prestige it provides. The opinions of clients, other unit staff and hospital administrators, for example, were not solicited. Each of these groups can have significant impact upon the status of the therapeutic recreation professional. Additionally, the diversity of organizational/administrative systems (e.g., job descriptions, treatment team composition, numbers of various professionals) on the units which were studied limit the generalization of findings.

Nonetheless, the often stated (Peterson, 1981; Meyer, 1981; Navar, 1981) need for increased professionalism in therapeutic recreation is supported. Hunnicutt (1980) has presented the case that there are limits to the professionalization of therapeutic recreation. A lack of understanding and respect for the field by unit directors suggests

that these limits have not been reached. Peterson (1981) has perceived the challenge as follows:

> As hard to understand as it may be, we must realize that each of us as individuals makes an impact only to the degree that the entire field makes an impact. In order to establish this greater level of impact, we must become more aware and involved with the entire profession of therapeutic recreation. We need to understand all aspects of professionalization; we need to contribute to the profession; and we need to feel an identity with all other professionals in the field (p. 7).

A Recommendation. Additional study focusing upon the attitudes, perceptions and misconceptions of others towards our profession may provide valuable information which can help therapeutic recreators meet the challenges of professionalization. Such studies may give direction to our efforts toward understanding and defining our own professionalism as well as that of other individuals in the allied health fields.

A Challenge. Justifiably we take pride in the energy, creativity, and skill with which we facilitate leisure services. We need to apply these same characteristics to our professional growth. Failing this we will remain locked in a second-class professional status; our clients denied the full potential of our services.

List of References

Hunnicutt, B. K. "To Cope in Autonomy: Therapeutic Recreation and the Limits to Professionalization and Intervention." Expanding Horizons in Therapeutic Recreation VII. Edited by G. Hitzhusen, et al. Columbia, MO: University of Missouri, 1980.

Navar, N. "A Study of the Professionalization of Therapeutic Recreation in the State of Michigan." Therapeutic Recreation Journal, Vol. 15, No. 2 (1981), 50-56.

Meyer, L. E. "Three Philosophical Positions of Therapeutic Recreation and Their Implications for Professionalization and NTRS/NRPA." Therapeutic Recreation Journal, Vol. 15, No. 2 (1981), 7-16.

Packard, V. The Status Seekers. New York, NY: David McKay Co., Inc., 1959.

Park, D. C. "Therapeutic Recreation in the New Decade." Expanding Horizons in Therapeutic Recreation, VIII. Edited by G. Hitzhusen, et al. Columbia, MO: University of Missouri, 1981.

Peterson, C. A. "Pride and Progress in Professionalism." Expanding Horizons in Therapeutic Recreation VIII. Edited by G. Hitzhusen, et al. Columbia, MO: University of Missouri, 1981.

Chapter 6

THE EFFECTS OF A TREATMENT PROGRAM FOR CHRONIC PAIN PATIENTS USING RELAXATION TECHNIQUES, ENJOYABLE IMAGERY, AND BIOFEEDBACK

Patrick James McKee*

Introduction

Relaxation provides an opportunity for freedom and pleasure. It is a capacity to be nurtured by each of us. Alexander Reid Martin has identified relaxation as one of our inner resources for leisure (Martin, 1975). Relaxation has a place in our understanding of leisure. Whether expressed as recuperative relief from the stream of life (Dumazedier, 1967; Selye, 1978) or enjoyed for its own sake -- pleasurably, mentally, physically, or spiritually -- relaxation contributes to leisure.

Therapists and teachers have encouraged relaxation techniques as tools for recovery from illness as well as for preventative health care.

The study described here examines the effectiveness of specific relaxation exercises designed to relieve pain in

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patients who have experienced high levels of discomfort over more than a year. Pain clinic patients commonly experience considerable stress and have difficulty relaxing physically and mentally. The treatment program described here presents strategies for learning relaxation and reducing pain associated with muscular bracing and tension.

> The extraordinary utility of muscle biofeedback in relieving all varieties of human problems is convincing us of the role of muscles as expressors of a great complex of mind and body activity. Even the most subtle of the mind's machinations, even the most sophisticated of the body's nerve electrical actions, have now been demonstrated to be intimately tied to a maelstrom of unfelt, unseen muscle activity . . . . The system consists of a perceptual-cerebral feedback loop and a muscle-cerebral feedback loop which dynamically interact with each other to sustain both the subjective and muscle states of tension; the effect of excessive tensions can be relieved by either the muscle or the cerebral tension (Brown, 1977, p. 36).

Relaxation Techniques. Learned relaxation for the treatment of emotional and psychosomatic disorders was best advocated by Edmond Jacobson (1938). He outlined a technique called progressive relaxation. This procedure progresses through all the muscles of the body, alternately tensing and relaxing muscle groups. Jacobson's major contribution was his thesis that anxiety and relaxation are mutually exclusive; that anxiety does not, cannot, exist when muscles are truly relaxed. Jacobson's technique is based upon contrasting tension with relaxation for specific muscle groups. A person often has little awareness of the sensation of relaxation, or the difference between tension and relaxation. Alternating between tensing and relaxing helps an individual to discriminate between the two (Jacobson, 1958, 1970).

Biofeedback and Self-Regulation. Several studies have supported the use of biofeedback to support relaxation learning (Budzinski, 1973; Hutchings, et al., 1975; Cox, 1975; Haynes, 1975).

Biofeedback can be understood by looking at the roots of the term. The prefix "bio" refers to biology or human physiology, and "feedback" refers to the return of information. Simply stated, biofeedback is the delivery of information about bodily process to the individual (e.g., use of an oral thermometer gives information to an individual about body temperature that normally is not available). Currently, widespread use of the term has a special meaning referring to technical information provided about very specific aspects of human physiology (Basajian, 1975; Brown, 1974; Budzynski, 1969; Gaardner, 1977; Karmiya, 1968). Feedback occurs throughout the body maintaining a balanced homeostatic system. Biofeedback as discussed here refers to information received about muscle tension. This information is precise, specific, immediate, and generated by a very small electrical impulse within muscles.

While the concept of biofeedback is straightforward, its use today implies sophistication in instrumentation and methodology. Internal processes are not often brought to our conscious awareness. Biofeedback allows monitoring to otherwise involuntary bodily processes. Biological signals of tension and relaxation are brought to the mind's attention and "information provided through biofeedback can enable learned control of muscle tension and associated pain" (Whatmore & Kohli, 1974; Wickremasekera, 1976; Hendler, et al., 1977).

Methodology

The purpose of this study was to evaluate the effects of a treatment program using biofeedback-assisted deep relaxation with enjoyable imagery. Changes in four groups of chronic pain patients were measured by the following dependent variables: (1) experience and intensity of pain; (2) depression, (3) leisure attitudes, (4) daily leisure activity, and (5) ability to relax.

Subjects. The subjects of this study were 20 patients referred to the Center for Health Assessment and Treatment, a clinic for chronic pain treatment, in Golden Valley, Minnesota. Referral to the treatment program was based on medical and psychological diagnostic evaluation of patients with prolonged intense pain. The medical staff excluded referrals on the basis of chemical dependency, psychosis, or specific medical contraindications. Typically, the patient population ranged in age from 25 to 50 years. Subjects were excluded who reported prior training in biofeedback therapy.

Experimental Design. Subjects were randomly assigned to four groups of five with the constraint that males and females were balanced as well as possible. The four groups were:

(1) **Imagery Biofeedback.** These day treatment subjects received biofeedback and relaxation training combined with enjoyable imagery.

(2) **Biofeedback.** These day treatment subjects received biofeedback and relaxtion training.

(3) **Day Treatment Only.** These day treatment subjects received no other treatment.

(4) Control Group. These subjects were a non-treatment waiting list control.

Figure 1 shows an outline of these four groups and their treatment conditions.

Pre-Testing. The dependent variables pre-tested included:

1. Intensity of pain as measured by a daily self-report scale of 1 to 10 with 10 as most intense.
2. Depression as measured by two self-report instruments, the MMPI (Minnesota Multiphasic Personality Inventory) and the Zung Scale.
3. Leisure attitude as measured by the Crandall Leisure Attitude Scale (Crandall, 1980).
4. Amount of daily leisure activity as measured by self-report of the average number of hours subject felt able to relax and enjoy daily activity.
5. Ability to relax as measured by frontalis EMG microvoltage level (muscle tension measured across the forehead, the most reliable single site indicator of tension in the body).

Each variable was assessed for baseline and posttest values. Specific instrumentation, protocol and measurement followed guidelines established by McKee (1981).

Treatment Procedures. The relaxation training phase of the experiment for all treatment subjects involved one session a week for approximately 50 minutes each, totalling nine sessions. The first session for all subjects consisted of an introductory presentation by a registered nurse covering scheduling and charting procedures and explaining the concept of learned relaxation. In addition, a

diagnostic evaluation of ability to relax using muscle biofeedback measurement was conducted with each group.

With the second session training in biofeedback and relaxation began emphasizing proper breathing using the diaphragm.

A third session for both biofeedback groups continued to focus on breathing and introduced the concept of tensing and relaxing specific muscle groups. The goal of this session was to enable the patient to distinguish between tension and relaxation in most skeletal muscle groups while receiving contingent biofeedback (feedback based on actual levels).

The fourth session for both biofeedback groups consisted of a taped relaxation training session continuing the development of control over muscular tension by using muscle biofeedback, EMG, monitoring. Each of the EMG sessions began with a five-minute baseline trial during which microvolt levels without biofeedback or relaxation exercise tapes were averaged and recorded.

Beginning with the fifth session, the two biofeedback treatment groups split. Group One, the imagery treatment group, began the use of imagery with session five and continued its use through session nine. Group Two, not receiving enjoyable imagery as part of treatment, continued with a series of taped relaxation exercises that were part of the clinic protocol. Sessions five, six, seven, eight, and nine consisted of a taped series copyrighted by Charles Stroebel called, The Quieting Response Training. Group Three served as a control for day treatment methods. Group Four was a waiting list control group receiving no treatment but admitted for treatment later. (Figure 1 outlines all treatment conditions.)

WEEK	Pre-Testing of Pain Intensity, Depression EMG Level, Leisure Attitude and Activity Level			
	Group 1 Imagery-Biofeedback (N=5)	Group 2 Biofeedback (N=5)	Group 3 Day Treatment (N=5)	Group 4 Control (N=5)
1	Biofeedback assisted relaxation training followed by feedback session	Biofeedback assisted relaxation training followed by feedback session	Day Treatment Program Only	No Contact
2	"	"	"	"
3	"	"	"	"
4	"	"	"	"
5	Begin use of imagery with biofeedback learning	"	"	"
6	"	"	"	"
7	"	"	"	"
8	"	"	"	"
9	"	"	"	"
10	- - - - - - - - - - - - - Posttest Battery Administered for All Four Groups - - - - - - - - - - - - - - - - -			Admitted for Treatment

Fig. 1--Research Design Showing Treatment Conditions (N=20)

The use of enjoyable imagery as an adjunct to biofeedback training for treatment Group One was based on the concept that "It's good to picture yourself as enjoying life." Imagery is meant to provide cues or resources for generalization beyond treatment. The procedure provided powerful reminders or suggestions that patients give themselves when they choose. Imagery was meant to suggest to individuals that it is possible to effectively handle a stressful situation, just as during relaxation training sessions earlier.

These exercises encouraged relaxation in general, replaced self-critical thinking, and served as a focal point during relaxation. They were useful for daily practice outside of treatment, and assisted in cultivating enjoyment.

It was explained to the patient that ability to imagine varies from person to person. Being able to visualize easily was not a prerequisite to using these exercises. Imagery selected was less detailed, often with a single simple image rather than a sequence of events; and particularly practice using imagery exercises in a supportive environment was encouraged.

At the end of session four, a take-home self-select imagery packet was given to all subjects. Each subject was then asked to select those imagery descriptions most appealing for use in the following sessions. Representative images that were suggested included: drifting in a clear pond on a warm day; the rhythm of a bird in flight; lying in a soft bed of grass; graceful swimming; being comfortable in a favorite place; feeling strong, relaxed body parts; breathing deeply and easily; being with a close friend; smooth, soft, loose muscles; and colors associated with warmth.

The first treatment involving imagery began with session five. This session consisted of guided imagery based on recollection of a past enjoyable experience. The first imagery session, and each of the remaining sessions, included a five-minute baseline, followed by imagery rehearsal, biofeedback training, and closure.

Session six began with a baseline period, continued with an imagery session, and concluded with biofeedback training. This session was comprised of relaxation instructions, attention to muscular tension and relaxation, and emphasized self-control and enjoyment through the visualization of a variety of images.

The seventh session was composed of imagery that had been chosen by each subject. Headphones for reducing external noise were offered to subjects as an option during feedback.

A one-way ANOVA was utilized to determine whether the four subject groups were significantly different at pretest and posttest with respect to each of the dependent variables: (1) pain intensity, (2) depression, (3) leisure attitudes, (4) amount of leisure activity, and (5) ability to relax.

Orthogonal planned comparisons were used to measure significant differences between selected, relevant, group pairs following treatment.

Results

Table 1 displays pretest and posttest data for each of the dependent variables across four groups. Analysis of variance followed by orthogonal comparisons revealed significant differences on measures of pain intensity, daily leisure activity and ability to relax (EMG).

TABLE 1

Group Means and Standard Deviations of Pre-Test, Post-Test and Change Scores on Pain Intensity, Zung Depression, MMPI Depression, Leisure Attitude, Leisure Activity and EMG Level (n = 20)

Group	Pain Intensity		MMPI Depression		Zung Depression		Leisure Attitude		Leisure Activity (hrs)		EMG Level	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
1. Imagery Biofeedback (n = 5)												
Pre-Test	7.4	1.8	24.2	6.2	50.8	9.6	28.4	2.7	1.1	1.2	4.9	1.5
Post-Test	3.8*	1.9	21.8	5.8	45.8	12.3	30.4	2.9*	2.9	1.2	1.5*	1.0
Change	-3.6		-2.4		-5.0		2.0		1.8		-3.4	
2. Biofeedback (n = 5)												
Pre-Test	7.3	1.2	25.0	3.4	57.6	12.7	27.6	3.8	0.6	0.6	6.3	2.7
Post-Test	4.0*	1.2	22.6	3.6	52.8	-4.5	31.4	4.2	2.1*	0.9	2.9*	0.9
Change	-3.3		-2.4		-4.8		3.8		1.5		-3.4	
3. Day Treatment (n = 5)												
Pre-Test	6.8	1.3	27.8	2.4	59.6	5.9	26.8	5.6	0.8	0.8	6.9	4.6
Post-Test	7.3*	1.2	26.0	2.5	58.6	7.2	27.4	6.5	0.9*	1.2	7.2*	4.4
Change	0.5		-1.8		-1.0		0.6		0.1		0.3	
4. Control (n = 5)												
Pre-Test	7.2	0.8	23.8	4.4	50.2	6.4	28.2	6.6	1.5	1.0	9.0	5.8
Post-Test	7.8*	1.0	24.2	4.2	50.6	7.3	27.6	5.2	0.9	0.7	12.9*	3.1
Change	0.6		0.4		0.4		-0.6		-0.6		3.9	
TOTAL												
Pre-Test	7.1		25.2		54.5		27.7		1.0		6.8	
Post-Test	5.7		23.6		51.9		29.2		1.7		6.1	

* Indicates significant differences at the $p \leq .05$ level

Compared to control subjects, experimental subjects (groups 1 and 2) reported:

1. less pain after treatment;
2. greater ability to relax, lower baseline frontalis muscle tension after treatment;
3. greater increases in amount of daily activity enjoyed after treatment.

Analysis of variance produced no significant differences on measures of depression or leisure attitude between groups after treatment.

Discussion

The significant findings indicate that ability to relax can be improved using strategies combining relaxation techniques and biofeedback. In addition, the treatment program appears to be an effective therapeutic tool for reducing pain.

Trend Analysis. A graphic illustration of group differences in pain intensity and EMG level is shown in Figures 2 and 3, respectively.

Figure 2 illustrates the trend of pain levels for each group from pretest to posttest across nine weeks of treatment. There is a definite, decreasing linear trend apparent in the two biofeedback groups. All groups start out with no significant differences averaging 7.1 on the pain intensity scale. While the two biofeedback groups drop in a linear regression to levels of 3.8 and 4.0 for groups 1 and 2, respectively, the two control groups increase slightly over treatment with pain intensity scores of 7.3 and 7.8 for groups 3 and 4, respectively.

Figure 3 illustrates the trend for EMG levels, representing ability to relax for each group from pretest to

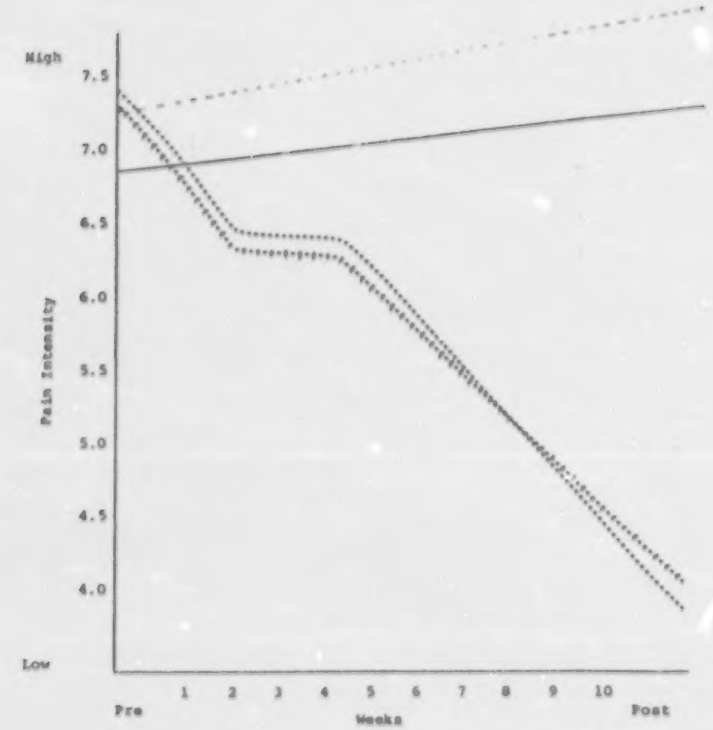

Fig. 2--Trend of Pain Levels as a Function of Time for Each Group

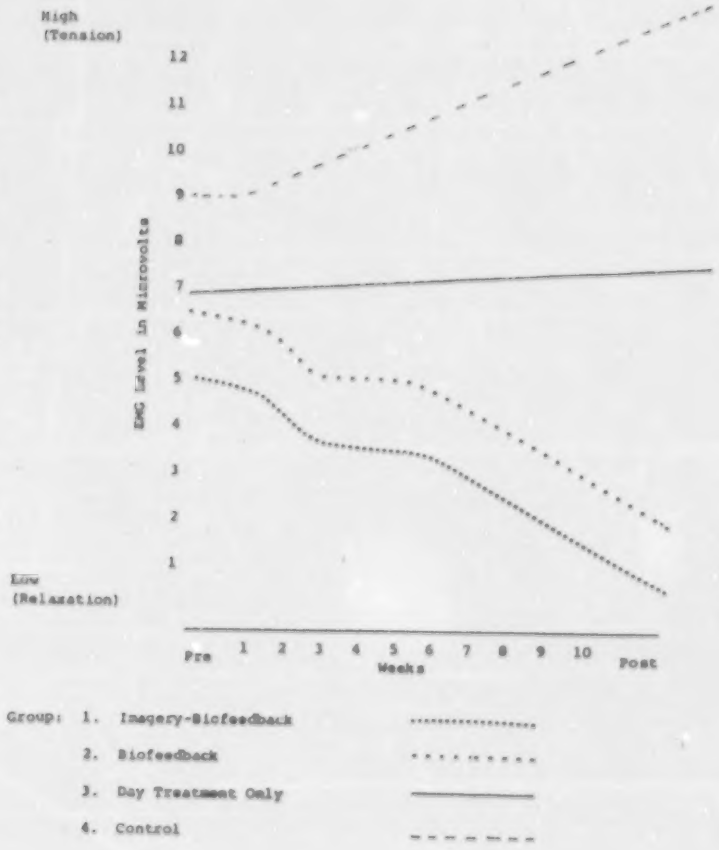

Fig. 3--Trend of EMG Levels as a Function of Time for Each Group

posttest across nine weeks of treatment. The trend is again a definite linear regression apparent in the two biofeedback groups. All groups started out with no significant differences on measures of EMG level, averaging 6.8 microvolts. The two biofeedback groups, the Imagery Biofeedback and the Biofeedback groups, dropped from 4.9 and 6.3 to 1.5 and 2.9, respectively. The two control groups, Day Treatment Only and Control, increased in microvoltage levels from 6.9 and 9.9 to 7.2 and 12.9, respectively, representing higher tension levels over nine weeks.

An interesting pattern of learning is suggested by consideration of the trend of the two biofeedback groups over the first half of treatment. Both treatment groups experienced a learning plateau during weeks three through five on EMG level. A similar pattern was evident on measures of pain intensity. These plateaus should be interpreted considering a consistent phenomenon during this two-week period. Patients were consistent in voicing expectations of a curative nature. Medical models of treatment were very familiar to all of these subjects. A consistent expectation based on this model maintained the belief that some specific cure was available for pain relief. Drugs and surgery were commonly accepted medical interventions for pain relief, and biofeedback was mystified as a "new cure" for many patients almost immediately and despite concerted efforts to define the self-care role of biofeedback therapy.

During the third week a pattern of discovery became evident. Usually accompanied by anger, patients experienced a realization that the biofeedback instruments did not "take away pain." Though it was repeatedly suggested that biofeedback is primarily a learning process, patients seemed to need to discover for themselves that getting well

involved self responsibility and control. This period of plateau in EMG and pain levels was, for most patients, distributed over a two-week period and is graphically illustrated in Figures 2 and 3. Patients frequently verbalized expected "cures" during the same period in which learning plateaus appear in the data on pain intensity and EMG levels. Further study investigating trend effects is strongly recommended. It may be, for example, that an optimum length of treatment would be verified by future trend analysis.

Patients in the two biofeedback groups showed greater increases in amount of daily activity enjoyed than Day Treatment Only or Control groups. This finding might be interpreted to suggest that the process of biofeedback-assisted relaxation, by reducing pain levels for the subjects involved, enabled increased activity. This interpretation is strengthened by the findings discussed earlier showing that the same groups significantly increased ability to relax and decreased pain levels.

These results may be supported by another interpretation. Initial inability to relax followed by learned ability to relax encouraged and enabled enjoyable activity and at the same time contributed to pain relief.

Reports of inability to relax coincided with low levels of activity enjoyed. Daily self-reports of activity enjoyed showed less than one hour's time was spent that could be called enjoyable for the average subject at pretest (see Table 1). Often daily reports would show "none" for activity enjoyed and patients would insist enjoyment was impossible with the pain and tension they experienced.

Gradually measures of activity level began to rise in the two biofeedback groups. Activity levels did not dramatically increase but a variety of activities began to be

reported showing a more balanced attention to capacities rather than only the incapacity accompanied by pain. As EMG levels decrease, participation in activities were more frequently reported as enjoyable activity. A wide variety of activities requiring greater physical exertion was more common as treatment progressed. Mutual recognition and encouragement followed reported increases in activity and enjoyment.

The data show an inverse, though not significant, relationship between pain intensity and enjoyed activity levels. Further study of this relationship is suggested. More sophisticated measurement of leisure activity may be required to detect a strong relationship. The small sample size (n=5) of this study requires unusually high values of r -- greater than .89 -- for significance. Therefore, an increased sample size is recommended in further study.

Summary

Based on the results of this study further research will be implemented. First will be a follow-up evaluation of the subjects of this study to investigate changes after treatment and possible trend effects. Second will be a replication of this study with a larger sample and some internal analysis of self-report measures.

These findings are encouraging. Relaxation skills combining biofeedback and enjoyable imagery are effective coping skills. One of the most significant features of relaxation learning is that it gives a person the opportunity for self-care rather than being the passive recipient of a therapeutic procedure. Particularly with a pain patient population, effective paths to reduce a person's

feeling of helplessness and increase a feeling of control of efficacy deserve study.

Health problems related to stress and inability to relax are not unique to pain patients. They are increasingly common today (Pelletier, 1977; Selye, 1978). In the future, recreators and health care professionals may find relaxation techniques a powerful, preventative, self-care measure -- a resource for holistic health, wellness and leisure.

List of References

Budzinski, T. H., et al. "EMG Biofeedback and Tension Headache: A Controlled Outcome Study." Psychosomatic Medicine, Vol. 35 (1973), 484-496.

Crandall, R. Leisure: A Psychological Approach. Los Alamitos, CA: Hwang Publishing Company, 1980.

Cox, D. J., Freundlich, A., and Meyer, R. G. "Differential Effectiveness of Electromyograph Feedback, Verbal Relaxation Instructions and Medication Placebo with Tension Headaches." Journal of Consulting and Clinical Psychology, Vol. 6 (1975), 892-898.

Dumazedier, J. Toward a Society of Leisure. London, England: Collier, 1967.

Haynes, S. N., Moseley, D., and McGowan, W. T. "Relaxation Training and Biofeedback in the Reduction of Frontalis Muscle Tension." Psychophysiology, Vol. 12 (1975), 547-552.

Hendler, N., et al. "EMG Biofeedback in Patients with Chronic Pain." Diseases of the Nervous System, Vol. 38 (1977), 505-509.

Hutchings, D. F., and Reinking, R. H. "Tension Headaches: What Form of Therapy is Most Effective?" Journal Biofeedback and Self-Control, 1975.

Jacobson, E. Progressive Relaxation. Chicago, IL: University of Chicago Press, 1938 (1958).

_____. Modern Treatment of Tense Patients. Springfield, IL: Charles C. Thomas, 1970.

Martin, A. R. "Leisure and Our Inner Resources." Parks and Recreation, Vol. 10, No. 3 (March, 1975).

Pelletier, K. Mind as Healer, Mind as Slayer. New York, NY: Del Publishing Co., Inc., 1977.

Selye, H. The Stress of Life. New York, NY: McGraw-Hill, 1978.

Whatmore, G. B., and Kohli, D. R. The Physiopathology and Treatment of Functional Disorders. New York, NY: Grune and Stratton, 1974.

Wickremasekera, I. Biofeedback, Behavior Therapy, and Hypnosis. Chicago, IL: Nelson Hall, 1976.

SOME USES OF THE MULTI-MODAL MODEL OF CURRICULUM EVALUATION IN THERAPEUTIC RECREATION

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Introduction

The multi-modal of curriculum evaluation was first developed and field tested upon a master's degree program in therapeutic recreation in 1978. In 1979, the model was revised and used to evaluate an entire master's degree program at another university. In 1980, the multi-modal model was further tested at a national level therapeutic recreation continuing education program. Most recently, the model was implemented at a regional in-service type of continuing education program in therapeutic recreation. Thus, although the basic evaluation model has remained the same, it has been revised and improved at each use. The purpose of this chapter is to disseminate information about the model as it has evolved to its current state and to highlight how this particular evaluation model may be used by persons in need of evaluating either regular or continuing education programs in therapeutic recreation. First,

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just what is the multi-modal model of curriculum evaluation?

The Model in Brief

The multi-modal evaluation model is a triangulated or composite approach to curriculum evaluation which uses a systematic combination of established techniques and procedures to gather both qualitative and quantitative information about a curriculum or program. In the case of the studies reported here, the model employed such techniques and procedures as interviews, questionnaires, document analysis, and observation. This occured in order to provide systematic information about a curriculum or program for the purposes of evaluative description and the judgment of worth or merit (Howe, 1978: 158). Considering there are at least a dozen categories of evaluation models and a number of models within each category, why should another model be added to the collection?

Need for the Model

Several authors in education and leisure studies have categorized the existing models of curriculum or program evaluation. Many of the models contain elements that are appropriate for the evaluation of therapeutic recreation programs. However, none is completely oriented towards the evaluation of therapeutic recreation programs in particular. A model which systematically integrates these elements is needed. This need led to the development of the new model.

The advantage of developing such a model is in the creation and dissemination of a clearly depicted tool for

evaluation. Inquiry is given direction in terms of purpose, context, focus, and criteria. Thus, the purpose of the model is to collect reliable and valid information from a variety of sources and to reduce and summarize this information in order to improve and make judgments about curricula or programs. The focus is the use of the model as a tool to help determine if, for example, a therapeutic recreation curriculum adequately prepares students to assume professional positions based on the perceptions of perhaps current students, past graduates, and the employers of past graduates. The context is the evaluation site or the place in which the phenomenon being evaluated occurs. The criteria are the operationalized value dimensions along which judgment is made.

The Evaluation Approach in Greater Detail

Most evaluations begin with the formulation of the significant concerns of the evaluation or the questions which the study is designed to answer. For the purpose of a typical evaluation report, an overall evaluation question might be: Does the curriculum in therapeutic recreation adequately prepare students to assume a particular, defined professional role as perceived by the current students, recent graduates, and employers of the graduates? To answer an evaluation question such as this, the multi-modal model of curriculum evaluation would use a systematic combination of existing components of other evaluation models specifically to judge the quality of a curriculum in therapeutic recreation as professional preparation. The model is highlighted in Figure 1.

In keeping with the example of a graduate level curriculum in therapeutic recreation, in the field setting

interviews, questionnaires, document analysis, and observation are used to describe and evaluate. This means that multiple or triangulated data collection techniques are systematically employed to collect both qualitative and quantitative data on which to base evaluative decisions. Therefore, the model is conceptualized to apply ethnographic or social science research methods to the discovery of information of importance to several audiences: program developers, participants, and other relevant decision-makers.

Category	Purpose	Proponents	Audience	Assumes Agreement
Composite Models	Description and judgements of worth for program revision and improvement	Howe, 1977 Rusk, 1979 Christiansen, 1981	Concerned decision makers	Standards qualifications and evalution acities

Methodology	Results	Problems
Observation, interviews, questionnaires, and document analysis	Description of educational program for improvement	Newness of approach applied in this way

Fig. 1--Multi-Modal Model of Curriculum Evaluation

Several other factors have contributed to the evolution of the multi-modal model. As suggested by Clark (undated) and Gardner (1977), the systematic combination of elements from the professional judgment models, the objectives-oriented models, and the transaction-observation models

provides a composite way to evaluate a program. The multi-modal model allows the evaluator to systematically refine the triangulation process into a series of repeatable steps. Triangulated research is the combination of several methods to study the same phenomena in order to examine them from as many methodological perspectives as possible (Denzin, 1970: 297). This use of more than one method fully grounds and verifies theory (Glaser and Strauss, 1974). The multi-modal model triangulates both quantitative and qualitative methods. Thus, through the instrumentation and analysis of the data, an indepth picture of the program becomes available.

Also, to enhance practical utility, the model's evaluation design is simple. A high degree of "numerical" measurement is not required. Human concern and the potential relevance of unanticipated outcomes are of great importance. Beyond that, the fact that programs and curricula in therapeutic recreation lack traditional measurement data is easily contrasted with the availability of human resources -- experts who have knowledge of therapeutic recreation and/or evaluation. Thus, the model was designed to provide a clear path to evaluative inquiry via the systematic use of both qualitative and quantitative methods of data collection and analysis. That is why the model is named multi-modal. The model is based on the premises that evaluation is a constructive activity, evaluation is both an art and a science, and evaluation works best in an open environment with participation by a broad cross-section of people. That, in summary, is the model and the evaluation approach. Now what about the process?

The Evaluation Process

Continuing with the example of a curriculum evaluation enables the illustration of the evaluation process. In light of the description of the model and in order to answer the major evaluation question in the example, six areas, or curriculum components, could be selected to form the basis of the evaluation design. The six example components that are chosen here include: (1) curriculum goals or competencies; (2) curriculum content; (3) curriculum organization; (4) guidance and advising; (5) instructional transactions, and (6) goal or competency achievement. There are others that could be selected. They must relate to the overall evaluation question.

For each of the components, a series of questions and data-gathering instruments are developed. The curriculum components, questions, instruments, and sources of data form the **evaluation design.** An illustrative design is shown in Figure 2 (see Appendix). These components and the associated questions and procedures form the core of the model and what has been tested, evaluated and revised. For more detailed information on the actual trials of the model, the reader is urged to contact the authors mentioned in the list of references at the end of this chapter for their designs and full instrumentation.

When examining the design, it is easy to see the evaluator must have access to all relevant information, whether that is a document or an interview with a specific person. Secondly, the evaluator must have the resources to conduct a full-fledged study: time, money, support personnel and equipment. The evaluator must meticulously follow the scientific method and be ethically bound to objectivity due

to the potentially large amount of non-numerical information collected and the fact that most evaluators are also the developers or implementors of the program under study.

Now that the model is described, the approach under which it operates is given and the parts of the model are shown, how may the model be used?

The Use of the Model

If one is concerned about more than just the "performance outcomes" of students in a curriculum or participants in a continuing education program, then one should strongly consider using the evaluation model discussed here. If it is desired to know what happens during instruction itself, to understand the impact of the setting or milieu on the learning experience, and to be naturalistic and responsive, then a multiple-method evaluation that is conducted in the field is a most appropriate approach. The multi-modal model provides an indepth description or portrayal of what has occurred in an educational program. The evaluator used this description to make interpretations (or draw inferences if appropriate), to make judgments and then present recommendations or alternative courses of action. An alternative might be to retain and revise something in order to improve it in a specific way that can be expected to cause a certain action to happen. Through a naturalistic mode of inquiry, an evaluation design may be responsive to unanticipated information as it happens to emerge from the variety of sources tapped.

Thus, in using the model, the actual functioning of the system is examined. The complexity of reality is respected, thereby requiring multiple measures as opposed to

single indicators of behavior, and so on. Teaching/learning interactions are viewed and recorded. Many different kinds of data are collected from varied and diverse sources. These data are then cross-checked and verified with each other. The resultant evaluation report is written narratively to ensure that it is indeed comprehensible to the various evaluation audiences, and the role of professional judgement (as in accreditation) is valued as a plus.

So, the evaluation model as used and improved has been judged functional, feasible, appropriate, and relevant based on each implementation. The model adequately addresses the overall evaluation question through the evaluation design, evaluation questions, sources of information, and data collection instruments. The multi-modal model is feasible in terms of the constraints of time and resources. It is appropriate considering the nature of the suggested investigation approach, the problem, and the instrumentation. The model can be relevant to the areas of evaluation concern selected if the "recipe" is followed. The instrumentation is the main part of the model that has been revised over time and use.

It is encouraged that the model be additionally tested on other programs and curricula in therapeutic recreation by practitioners, students and educators to determine its feasibility and usefulness in other settings by other people. The model is intended to be shared with all of those persons interested in the evaluation of programs and curricula in therapeutic recreation. Other curriculum components and program activities that have not been included in the design to date should be developed and tested within the framework of the model and based on the purposes and needs of curricula and programs in other contexts. In

conclusion, it is hoped the model will continue to be implemented and improved with each use.

Appendix

Fig. 2--Curriculum Evaluation Design for the Multi-Modal Model of Curriculum Evaluation

CURRICULUM COMPONENT: Curriculum Goals or Competencies

Evaluation Question	Instrument	Source
Are there specified curriculum goals or competencies in existence?	Doc. Analysis Form 1	Documents
What is the source or reference for the curriculum goals or competencies?	Doc. Analysis Form 1	Documents
Describe the goals or competencies of the curriculum	Doc. Analysis Form 1	Documents
Are the goals or competencies relevant to the professional roles of a person who has a master's degree in therapeutic recreation?	Questionnaire and Interview	Current Students
	Questionnaire	Graduates & Employers

CURRICULUM COMPONENT: Curriculum Content

Evaluation Question	Instrument	Source
What is the source or reference for information about the linkage between the goals or competencies and the content of the curriculum?	Doc. Analysis Form 2	Documents
Describe the relationship between the goals or competencies and the content of the curriculum?	Doc. Analysis Form 2	Documents
Rate the quality of the curriculum content as preparation for a professional role	Questionnaire and Interview	Current Students
	Questionnaire	Graduates

CURRICULUM COMPONENT: Curriculum Content, cont.

Evaluation Question	Instrument	Source
Is a sufficient amount of the total master's degree program directly related to therapeutic recreation?	Questionnaire and Interview	Current Students
Is there unnecessary duplication of material between therapeutic recreation core courses and therapeutic recreation deficiency courses?	Questionnaire and Interview	Current Students
	Questionnaire	Graduates
Is there unnecessary duplication of material between departmental courses and therapeutic recreation courses?	Questionnaire and Interview	Current Students
Is there opportunity and support for pursuing professionally related activities	Questionnaire and Interview	Current Students
	Questionnaire	Graduates

CURRICULUM COMPONENT: Curriculum Organization

Evaluation Question	Instrument	Source
What is the source of reference for information about this sequencing of courses within the program?	Doc. Analysis Form 3	Documents
Describe the organization and sequencing of courses in the curriculum	Doc. Analysis Form 3	Documents
Describe the course sequencing within each of the five sub-areas: a. Departmental Core Courses b. Therapeutic Recreation Core c. Departmental Deficiency Courses	Doc. Analysis Form 3	Documents

CURRICULUM COMPONENT: Curriculum Organization, cont.

Evaluation Question	Instrument	Source
d. Therapeutic Recreation Deficiency Courses e. Practicum Experience		
How satisfied are you with the course sequencing in each of the five sub-areas	Questionnaire and Interview	Current Students
	Questionnaire	Graduates

CURRICULUM COMPONENT: Guidance and Advising

Evaluation Question	Instrument	Source
Is there a specified procedure for guidance and advising through the curriculum?	Doc. Analysis Form 4	Documents
What is the source or reference for the advising and guidance procedure	Doc. Analysis Form 4	Documents
Describe the guidance and advising procedure	Doc. Analysis Form 4	Documents
Rate the quality of guidance and advising in terms of advisor availability, knowledge of courses, concern, helpfulness in job placement, and facilitation through the curriculum	Questionnaire and Interview	Current Students
	Questionnaire	Graduates

CURRICULUM COMPONENT: Instructional Transactions

Evaluation Question	Instrument	Source
Rate the quality of the teaching and learning activities in each of the five sub-areas	Questionnaire and Interview	Current Students
	Questionnaire	Graduates

CURRICULUM COMPONENT: Goal or Competency Achievement

Evaluation Question	Instrument	Source
Rate your satisfaction with courses as preparation for a professional role	Questionnaire and Interview	Current Students
	Questionnaire	Graduates
Rate your satisfaction with your own competence	Questionnaire and Interview	Current Students
	Questionnaire	Graduates
Rate your satisfaction with your employee's competence	Questionnaire	Employer

List of References

Clark, W. W., Jr. Qualitative Methods in Evaluation: An Example From the Triangulated Evaluation of a Teacher Education Program. Unpublished manuscript, undated. (Available from Dr. W. W. Clark, The Institute for the Study of Social Change, University of California, Berkeley, California 94720).

Christiansen, C. The Revision and Evaluation of an Evaluation Model for In-service Training Programs Related to Mainstreaming. Unpublished master's thesis, San Jose State University, 1981.

Denzin, N. K. The Research Act. Chicago, IL: Aldine Publishing House, 1970.

Gardner, D. E. "Five Evaluation Frameworks." Journal of Higher Education, Vol. 48 (1977), 571-593.

Glaser, B. G., and Strauss, A. L. The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, IL: Aldine Publishing House, 1974.

Howe, C. Z. The Development and Evaluation of a Curriculum Evaluation Model for Master's Degree Curricula in Therapeutic Recreation. Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign, 1978.

Rusk, P. K. An Evaluation Report of the Master's Degree Curriculum in Recreation and Park Administration. Unpublished master's thesis, University of Missouri-Columbia, 1979.

A STUDY TO DETERMINE THE EDUCATIONAL LEVEL AND PRACTICAL EXPERIENCE OF COLLEGE TEACHERS IN THERAPEUTIC RECREATION: 1980

S. Harold Smith*
Robert W. McGowan**

Introduction

Therapeutic recreation course offerings have steadily increased in college and university curricula over the past ten years. Anderson and Steward (1980) have indicated a 500% increase from their research which ". . . suggest(s) dramatic professional growth during a period of 'educational survival' for many curricula." With this rapid growth in curricular offerings in Therapeutic Recreation has come a corresponding need for faculty to teach in these newly developed curricula. As one evaluates this tremendous growth spurt both in course offerings and faculty, at least two critical questions must be asked as they relate

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to professional development and quality control in therapeutic recreation. The first of these questions is, "What type of educational training and preparation do faculty teaching therapeutic recreation curriculum offerings carry?: The second, "What type of professional and practical experience have these same faculty acquired?" The assumption is that the successful teacher in therapeutic recreation would need both an adequate educational background as well as practical, hands-on, professional experience to successfully educate their students.

A review of the literature indicated at least three studies that related to these questions. Stein (1970, 1980) in his "Report on the Status of Recreation and Park Education in Canada and the United States" only partially addresses these questions as he openly states, "When reviewing information relating to educational background of faculty, we observe a significant decrease in Recreation Program Management in which we included all 'other' responses of Therapeutic Recreation. This was an arbitrary decision of the reporter in which I view Therapeutic Recreation as an option of the broader recreation field of study." Anderson and Stewart (1980), in attempting to duplicate the work of Stein in the select area of therapeutic recreation, do address the area of faculty degree and rank but do not address the important practical experience question. With this in mind, this research was designed to attempt to obtain data in both areas of educational preparation and practical experience of those teaching courses in therapeutic recreation.

Survey Procedure

A short, two-page questionnaire was developed with the first page addressing questions related to educational level, training and background and the second page addressing questions related to past, present, and future practical experience. Copies of the questionnaire were sent to the department head of each college and university listed in the 1979-80 Society of Park and Recreation Educators (SPRE) Curriculum Catalog. Each department head was asked in the cover letter to give the questionnaire(s) to each of their faculty teaching therapeutic recreation courses. Sixty-eight (68) completed questionnaires were returned of which 66 were actually used in the study. Although there is no completely accurate data on how many individuals there are actually teaching courses in therapeutic recreation, it was felt that this was a small, yet representative, sample.

Educational Level

Four categories of information were gathered relating to faculty education levels: current rank, years of teaching experience in therapeutic recreation, degrees held, and field of study (see Table 1). In the area of current rank it was found that 13 (19.7%) held the rank of instructor, 29 (43.9%) held the rank of assistant professor, while 16 (24.2%) held the rank of associate professor, and 4 (6.1%) held the rank of full professor. Four individuals (6.1%) were identified as either adjunct instructors or teaching assistants. In terms of years of experience it was identified that 18 (27.2%) of the teachers had taught for three years or less, 19 (28.8%) had taught for at least four years but less than six years, while 11 (16.8%) had taught

TABLE 1

Educational Experience

	No.	%
Degrees Held		
Doctorate	34	51.5
Masters	27	40.9
Bachelors	5	7.6
Degree(s) in Rec./TR		
None.	11	16.7
1	55	83.3
2	27	33.3
3	4	6.1
Current Rank		
Professor	4	6.1
Associate	16	24.2
Assistant	29	43.9
Instr./Lect.	13	19.7
Other	4	6.0
Years' Teaching Experience		
1 - 3	18	27.2
4 - 6	19	28.8
7 - 10	11	16.8
11 +	18	27.2

for at least seven years but less than 10 years, and 18 (27.2%) had taught for 11 years or more. Fifty-eight (87.9%) of the teachers taught full-time although not necessarily in therapeutic recreation.

All 66 teachers reported holding at least the bachelor's degree, which would be expected at this level of teaching. Five (7.6%) reported that they held only the

bachelor's degree, while 27 (40.9%) reported holding the master's degree, and 34 (51.5%) had achieved their doctorate. Of the 32 teachers not holding the terminal degree, 14 (43.8%) indicated they were currently working on it.

In the area of field of study, 11 (16.7%) of the teachers reported holding no degreee in recreation/therapeutic recreation, while 55 (83.3%) reported holding at least one degree in recreation/therapeutic recreation. Twenty-seven (33.3%) of the teachers reported holding two degrees in recreation/therapeutic recreation and 4 (6.1%) stated they held all three of their degrees in recreation/therapeutic recreation. Of the 34 teachers holding the doctorate, 9 (13.6%) identified their degree as being in therapeutic recreation, 15 (22.7%) identified their degree as being in recreation, while the remaining 10 (15.2%) reported holding degrees in closely allied areas.

Practical Experience

In an attempt to identify the length and type of practical experience acquired by each of the teachers, three basic questions were presented for their response. First each teacher was asked to indicate the number of years of full-time, paid, practical experience they had gained. Second, they were asked to indicate which population they served (see Table 2).

In response to the question on the number of years of experience, it was found that 9 (13.6%) of the teachers had no paid practical experience. Thirteen (19.7%) responded that they had one to three years of experience, 15 (22.7%) stated that they had from four to six years of experience, while 14 (21.3%) said they had seven to ten years of experience. Fifteen (22.7%) of the teachers had ten or more

TABLE 2

Practical Experience

	No.	%
Years Practical Experience		
0	9	13.6
1 - 3	13	19.7
4 - 6	15	22.7
7 - 10	14	21.3
11 +	15	22.7
Type of Experience		
Face to Face	34	51.5
Supervisory	32	48.5
Population(s) Served		
Psychiatric Client	47	71.2
Mentally Retarded	37	56.1
Physically Handicapped	21	31.8

years of experience. This information indicates that 86.4% of the teachers had at least one year of paid practical experience and that 66.6% had at least four years of paid practical experience.

Thirty-four (51.5%) of the teachers reported that their practical experience was as a face-to-face service provider. The remaining 32 (48.5%) reported their practical experience was as a program supervisor or director. A majority of the teachers (51.5%) also reported that their service provision was to more than one client population. Of the populations served, the psychiatric client was the most frequently served (71.2%), the mentally retarded second most frequently served (56.1%), and the physically

handicapped the third most frequently served (31.8%) population group.

In addition to the questions on past practical experience, each teacher was also queried about their current involvement in service provision, their desires for involvement in service provision in the future and their perception of the balance needed between practical experience and educational training. Over two-thirds (68.2%) of the teachers responded that they were currently involved in some type of service provision. Slightly less than two-thirds (62.1%) of the teachers expressed a need and desire to acquire additional practical experience of some type in the future. Although there were some very pointed responses on both sides of the question, a high majority (80.3%) of the teachers reported that they felt both educational training and practical experience are necessary components to be an effective teacher in a therapeutic recreation curriculum.

Conclusions

If one were to look only at the results of the study in statistical terms, it would be easy to conclude that the majority of teachers of therapeutic recreation courses are well qualified both through educational training and practical experience. As one begins to analyze the data, however, some interesting and serious observations are very apparent. It is necessary, therefore, to briefly address several of these observations.

1. Although it appears that the majority of teachers in therapeutic recreation have the necessary educational training, it is of some concern that almost 17% have no formal degree training in therapeutic recreation. It

is pleasing to know that over half (51.5%) hold the doctorate, yet it is somewhat disconcerting that Stein (1980) reports that 56% of all teachers in recreation hold the terminal degree. It is also of concern that only about 36% of the teachers hold the doctorate in Recreation or Therapeutic Recreation.

On the other hand, it is encouraging to note that 83% of the teachers held at least one degree and 33% held two degrees in Recreation/Therapeutic Recreation. It is also encouraging to note that 44% of those teachers not currently holding the terminal degree are actively pursuing one. From this information it is anticipated that in the near future the number of teachers in Therapeutic Recreation holding the doctorate will continue to increase both in numbers and percent of population, and that the number holding no degree in Recreation/Therapeutic Recreation will dramatically decrease.

2. Although 44% of the teachers reported more than seven years of practical experience, there are some questions as to the type of experience reported. It was our attempt to discover the number of years of full-time, direct-contact, front-line, paid experience. It is felt that many teachers reported consultation work, teaching, workshops, and intern supervision in this area. We agree that these are important experiences but they were not what we were really looking for. It is our feeling that a separate study specifically addressing types and length of practical experience is needed before much can be said in this area.

3. The fact that 49% of the teachers reported not having any face-to-face experience and that only 36% held the doctorate in Recreation/Therapeutic Recreation is some-

what alarming from a service provider's standpoint. It certainly raises interesting questions about what level of training is being provided for students in our various curriculums. It also raises some questions about the progress of the art/science of therapeutic recreation through sound observation and research.

Recommendations For Action

It would appear that these situations can be improved through several methods, some of which may be:

1. Encourage the development of a standardized curriculum in Therapeutic Recreation with evenly weighted input from both educators and experienced, successful practitioners.
2. Encourage practitioners to share insights and experiences through publications, classroom presentations and consultations.
3. Require 1-3 years of full-time, paid, face-to-face experience prior to admission to graduate school(s).
4. Encourage and support research efforts between educators and practitioners.
5. Require a thesis for all graduate degrees in Therapeutic Recreation.
6. Hold a close review of the NRPA/AALR accreditation process to ascertain whether it is helping or hindering the Therapeutic Recreation process.

It can be concluded that educators in the field are interested and involved in increasing their ability through continued education and direct patient/client involvement. Further, a group educators in therapeutic recreation recognize the need for a balance between formal educational

training and practical experience to be an effective educator. It must be realized, however, that we still have a way to go in the preparation and training of college teachers in Therapeutic Recreation.

List of References

Anderson, S. C. and Steward, M. W. "Therapeutic Recreation Education: 1979 Survey." Therapeutic Recreation Journal, Vol. 14, No. 3 (1980), 4-10.

Stein, T. A. "Report on the State of Recreation and Park Education in Canada and the United States." Washington, DC: National Recreation and Park Association, Society of Park and Recreation Educators, October, 1970.

_____. "Report on the State of Recreation and Park Education in Canada and the United States." Arlington, VA: National Recreation and Park Association, Society of Park and Recreation Educators, October, 1980.

Chapter 9

SYSTEMATIC CURRICULUM DEVELOPMENT

Stephen C. Anderson*
Helen A. Finch**

Introduction

The need for educators with graduate specialization in therapeutic recreation continues to increase. In a study completed by Anderson and Stewart (1980), it was indicated that 39 new therapeutic recreation educator positions would be available in the fall of 1979. However, this same study reported that only 18 therapeutic recreation doctoral students were expected to graduate during 1979. Therefore, because only 11 universities presently offer the doctoral degree with a concentration in therapeutic recreation, curriculum development has become a timely concern.

Curriculum development in therapeutic recreation has been studied by many individuals. A compendium of literature can be found in the following publications (Kelley et al., 1976; Jordan et al., 1977; and Austin, 1980). Many of the authors contributing to these publications focus on competency based education. Areas recommended for further study include:

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- indentifying competencies appropriate to different levels of instruction,
- validating competencies at different degree levels,
- establishing criteria for competency completion, and
- evaluating the effectiveness of the curriculum.

The purpose here is to present a model of systematic curriculum design which addresses the above concerns. The process is generic and thus related to any curriculum development effort.

Systematic Curriculum Development

Three major roles usually are associated with a college/university educator. As depicted in Figure 1, the roles of researcher, teacher, and consultant/service provider are identified and form the basis for the curriculum competencies needed to fulfill those functions. The figure provides a comprehensive view of the direction in which a graduate curriculum would be developed.

The process of curriculum development discussed here can be divided into three major phases. Phase I involves identifying competencies appropriate for a doctoral-level curriculum. When the set of competencies are validated, the second phase encompasses three tasks: clustering competencies, identifying corresponding learning activities, and developing a learning hierarchy. The third and final phase consists of extensive summative evaluation through implementation and monitoring of the curriculum and validation of the learning hierarchy. Each phase will be described in detail. Throughout this presentation reference is made to Figure 2, which offers a graphic representation of the narrative.

Phase I: Identifying Competencies

Competencies relating to graduate-level preparation in therapeutic recreation were collected from various sources, though a significant number of competencies are specific to

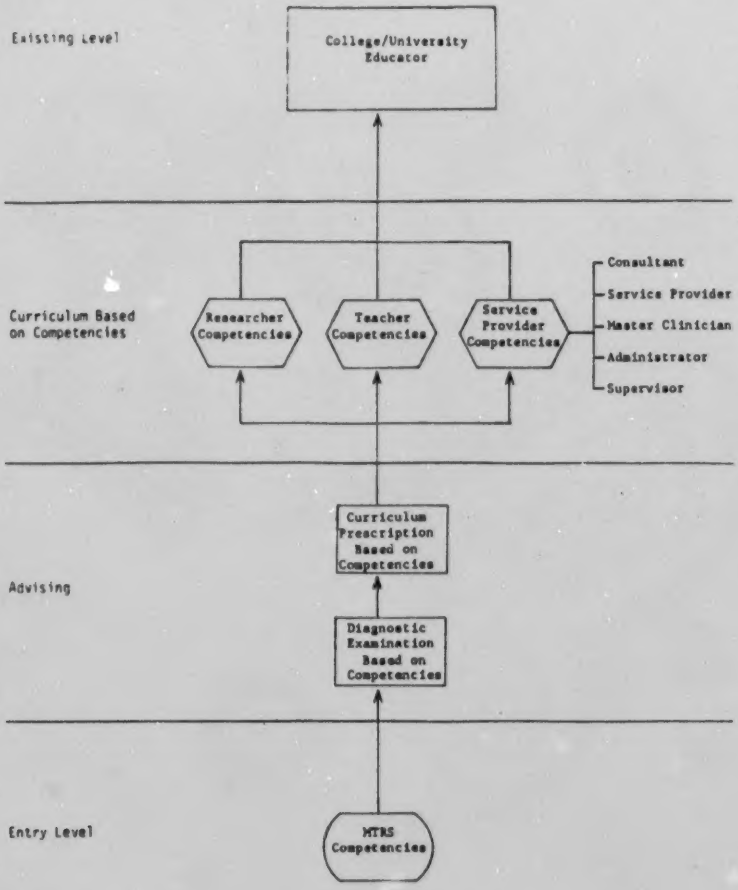

Figure 1

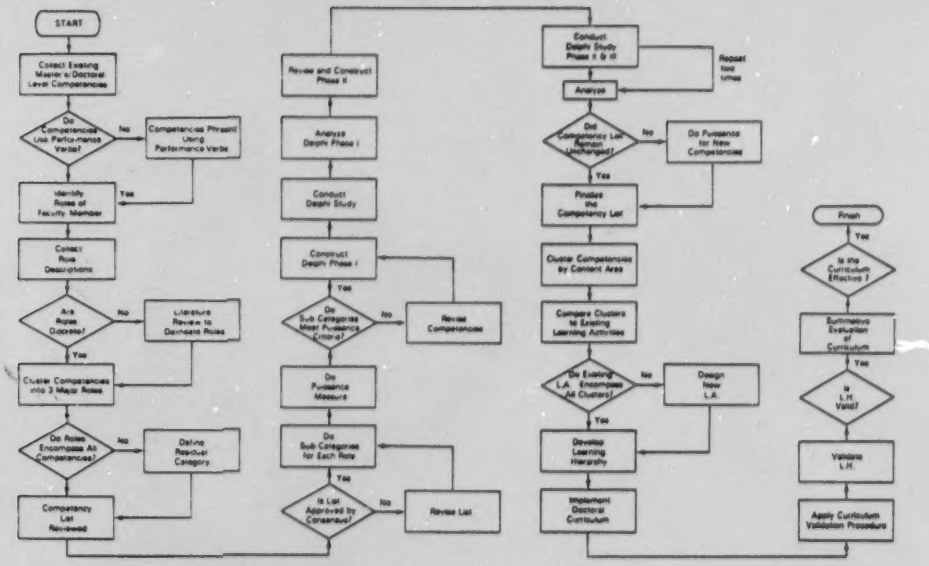
START
Collect Existing Master's/Doctoral Level Competencies
Do Competencies Use Performance Verbs?
No
Competencies Phrased Using Performance Verbs
Yes
Identify Roles of Faculty Member
Collect Role Descriptions
Are Roles Discrete?
No
Literature Review to Dominate Roles
Yes
Cluster Competencies into 3 Major Roles
Do Roles Encompass All Competencies?
No
Define Residual Category
Yes
Competency List Reviewed
Review and Construct Phase II
Analyze Delphi Phase I
Conduct Delphi Study
Construct Delphi Phase I
Yes
Do Sub Categories Meet Pursuance Criteria?
No
Revise Competencies
Yes
Do Pursuance Measure
Do Sub Categories for Each Role
Yes
Is List Approved by Consensus?
No
Revise List
Conduct Delphi Study Phase II & III
Repeat two times
Analyze
Did Competency List Remain Unchanged?
No
Do Pursuance for New Competencies
Yes
Finalize the Competency List
Cluster Competencies by Content Area
Compare Clusters to Existing Learning Activities
Do Existing L.A. Encompass All Clusters?
No
Design New L.A.
Yes
Develop Learning Hierarchy
Implement Doctoral Curriculum
Finish
Yes
Is the Curriculum Effective?
Summative Evaluation of Curriculum
Yes
Is L.H. Valid?
Validate L.H.
Apply Curriculum Validation Procedure

Figure 2

university programs. Through revising these lists, a set was constructed to reflect content at the doctoral level. The competencies were rewritten using standardized performance verbs and were compared to clarity and degree of specificity.

The majority of competencies were categorized under three roles: teacher, researcher, and consultant/service provider. Sub-categories within these roles were delineated and residual competencies were placed in a generic category. The competencies were reviewed by an in-house advisory committee. Following suggested revisions, sixty-one competencies were identified.

Measure of Strength. To assure competencies at an appropriately high level of difficulty, a puissance test was administered. Verbs, used in the competencies, were applied to a Quality Space Matrix, developed by Walbesser (1972). According to Walbesser, by multiplying the Performance Class by the Levels of Complexity for each competency and dividing by the number of competencies, a curriculum offered at the doctorate level should have an average of 15. The results of the first puissance test demonstrated that some of the competencies needed to be rewritten and their level of complexity increased. Attention was provided this task and a second puissance measure was administered. The efforts resulted in an acceptable level for a doctorate curriculum. An example of the Quality Space Matrix, applied to the sub-category of Educator/Evaluation, is found in Table 1. The illustration of Educator/Evaluation equals a power of 16.5, which exceeds Walbesser's criterion of 15 points for doctoral-level rigor. Additional sub-categories yielded similar results.

TABLE 1

Quality Space Matrix for Measuring Levels of Competencies

UNIT: Educator/Evaluation — PUISSANCE MEASURE: 16.5

Performance Class		Levels of Complexity					
		1 Non Verbal Chaining	2 Verbal Chaining	3 Multiple Discrimination	4 Concepts	5 Principle	6 Independently Generated Problem Solving
1	Name						
	Identify						
	State a Rule						
2	Order						
	Distinguish						
3	Construct						
	Describe						
	Demonstrate					1	
	Apply a Rule						2

Educator/Evaluation:

1. Demonstrate the ability to assess student progress.
2. Apply instructor/course evaluation systems.

Agreement of Competencies. The Delphi Technique (Gazzola, 1971 and Seweigert and Schabacker, 1974) was implemented to establish consensus regarding the generated competencies. Delphi I was distributed to a national jury of 20 members consisting of educators and doctoral students. The results indicated the need for revisions of the format and the addition of specific competencies. Delphi II was constructed to include the new competencies and clarification regarding the performance verbs. Results were tabulated by computing a mean for each competency and checking for movement toward consensus. Delphi III was distributed in identical form as Delphi II and, after tabulation, consensus was achieved. This systematic research method insured 100 percent return and the realization of the curriculum design goals.

The final task in the first phase of the process was the application of the puissance measure to all sub-categories. Repetition of this procedure insured that competencies added during the Delphi Technique did not alter the difficulty level of the sub-categories.

At the conclusion of Phase I of this study 78 competencies had been identified, categorized and measured for their level of complexity. Phase II outlines the procedure for clustering, identifying learning activities, and constructing a learning hierarchy.

Phase II - Operationalizing Competencies

Competencies were divided into 17 different clusters. In certain cases these clusters correspond to sub-categories such as Researcher-Methodology. Criteria for clustering competencies were: 1) competencies share a common knowledge base, and 2) clusters reflect placement of

learning activities based upon current trends in academic discipline. For example, the competency, "Demonstrate the use of the computer as a teaching tool," was clustered under educational technology rather than computer science to reflect curriculum trends.

For each cluster, learning activities are identified that correspond to:

- opportunities already in the existing curriculum, and
- courses/learning experiences that could be modified to include clusters.

Learning activities, which include courses, units, seminars, independent study, and practicums then are identified or developed for the 17 competency clusters.

The idea that learning is cumulative or sequential is a common-sense notion. One feels that a learner must master arithmetic before tackling algebra. As a result, certain courses may be listed as prerequisites for other courses. Also, a group of topics may be ordered in sequence within courses under the assumption that one topic should be studied before another. According to Gagne (1962), a learning hierarchy is "a set of specified intellectual capabilities having an ordered relationship to each other."

Creating a Learning Hierarchy. The general procedure for developing a learning hierarchy is to work backward, starting with the terminal task of instruction stated as a specific performance outcome. The educator asks, "What should the student be able to do after receiving the instruction?" The answer becomes the terminal objective and the educator then asks, "What must the student do before he can exhibit the terminal objective?" For each subordinate behavior, the procedure is repeated. The result is a learning hierarchy.

The third task in Phase II is to sequence the learning activities and develop a learning hierarchy. A given curriculum presently might contain prerequisites. It is assumed that the prerequisites were identified and the curriculum was developed through the backward chaining process. Current prerequisites in the recreation curriculum must be identified and the courses sequenced accordingly. The new courses and/or learning activities should be developed and plugged into the sequence where they are deemed appropriate. The result is a learning hierarchy for the curriculum.

A Caution. Any learning hierarchy developed by logical analysis should be viewed with caution until proven effective. Until validation, a learning hierarchy represents a series of untested hypotheses about the tasks leading to a final goal. Therefore, validation of the learning hierarchy must be conducted.

Phase III: Evaluation and Validation

After the courses/learning activities are sequenced into a learning hierarchy, the curriculum is ready to be implemented. To evaluate the curriculum thoroughly, the learning hierarchy must be validated. The hierarchy consists of numerous prerequisite courses which are considered subordinate behaviors, and the more advanced course is considered the terminal behavior.

Achievement in a course is denoted by a "1", and non-achievement is denoted by a "0". For the purposes of this procedure a grade of "B" (80 percent), or higher, signifies achievement. If the student acquired the terminal behavior and all of the hypothesized subordinate behaviors, the

ordered pair is (1,1). If the student acquired the terminal behavior of the hypothesis but not all of the subordinate behaviors, the ordered pair is (1,0). Similar interpretations can be given to the (0,0) and (0,1) ordered pairs. The sum of (0,0), (0,1), (1,0), and (1,1) for each hypothesis then is calculated using the Walbesser Validation Procedure (Cook and Walbesser, 1973).

This procedure contains the use of three ratios. The consistency ratio examines the relationship between acquisition of the terminal behavior of the hypothesis and acquisition of all subordinate behaviors. The adequacy ratio studies whether acquisition of all subordinate behaviors is adequate for the performance of the terminal behavior. The completeness ratio estimates the percentage of individuals capable of traversing the hypothesis as opposed to those incapable of performing at least one of the subordinate courses in the hypothesis. A hypothesis of a learning dependency is considered valid if its consistency, adequacy, and completeness ratios all are computed to be 0.85 or greater. A learning hierarchy is considered valid if each hypothesis is valid.

Summary

The purpose here was not to provide results of a specific study, but to demonstrate a process of curriculum development. The methodology included competency identification, a Delphi Technique to validate the competencies, and the introduction of a puissance measure to determine the difficulty level of each competency. Competency clustering was employed and emphasis placed on sequencing the clusters after learning activities were identified.

Validation of the learning hierarchy (curriculum) was explored and demonstrated.

The process, which is unique, serves as a demonstrative technique to assist others in the area of systematic curriculum development. Furthermore, the final product serves as a model for departments of recreation and leisure studies to incorporate into their overall program.

List of References

Anderson, S. C. and Stewart, M. W. "Therapeutic Recreation Education: 1979 Survey." Therapeutic Recreation Journal, Vol. 14, No. 3 (1980).

Austin, D. R., ed. Directions in Health, Physical Education, and Recreation. Monograph No. 1: Therapeutic Recreation Curriculum: Philosophy, Strategy, and Concepts. Bloomington, IN: School of HPER, Indiana University, 1980.

Cook, J. M. and Walbesser, H. H. How to Meet Accountability with Behavioral Objectives and Learning Hierarchies. College Park, MD: Bureau of Educational Research and Field Services, 1973.

Gagne, R. M. "The Acquisition of Knowledge." Psychological Review, Vol. 69, No. 4 (1962), 355-365.

Gazzola, P. G. "The Effects of the Delphi Technique on Group Consensus in Educational Planning." Unpublished doctoral dissertation, University of Arizona, 1971.

Jordan, J. J., Dayton, W. P. and Brill, K. H. Theory and Design of Competency-based Education in Therapeutic Recreation. Philadelphia, PA: Department of Recreation and Leisure Studies, Temple University, 1977.

Kelley, J. D., et al. Therapeutic Recreation Education: Developing a Competency-based Entry-Level Curriculum. Urbana-Champaign, IL: ORPR, University of Illinois, 1976.

Seweigart, R.L., Jr., and Schabacker, W. H. "The Delphi Technique: How Well Does it Work in Setting Educational Goals." Research paper presented at the annual meeting of the American Educational Research Association, Chicago, IL, 1974.

Walbesser, H. H. "Science Curriculum Evaluation: Observations on a Position." The Science Teacher, Vol. 33, No. 2 (1966), 34-39.

_____. "Behavioral Objectives, A Cause Celebre." The Arithmetic Teacher, Vol. 19, No. 6 (October, 1972), 436-440.

CREATIVITY: STRATEGIES FOR INNOVATIVE TEACHING AND PARENTING

Carol Stensrud*

Introduction

Creativity is hard to talk about. Creativity comes from the right side of our brain, and our verbal language comes from the left side. The left brain finds it hard to explain, analyze or talk about creativity. Charlie Brown explained this problem one day in a cartoon about love. He said to Peppermint Patty as he dropped his head in defeat, "I don't understand love; I can't even talk about it."

I do believe in creativity, even though I may not be able to define it specifically. I know what it feels like to be creative and enjoy being thought of as a creative person. Ironically, I also enjoy researching creativity and guiding people to creative ways of doing things.

This chapter is concerned about infusing creativity in the teaching and parenting of children with handicapping conditions. Parents, teachers and therapists who relate to these children often request help in finding new, innovative and creative ways to work and play with these

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children. They want lists, directions, specific activities, answers and maybe even a few miracles.

These lists, answers and activities soon grow old and stale and lose their innovation. I offer something else in the way of help -- hopefully a type of help that will provide parents, teachers and therapists with long-lasting benefits.

What I offer are strategies that some people, who we think of as creative, use in developing their ideas. No, we cannot really put our finger on the act of creation; yet we can pinpoint the strategies and processes that creative minds do utilize to come up with a package of creativity.

Creative people have been shown to have some observable characteristics, ways of behaving, attitudes and feelings. If we assume more and more of these characteristics and feelings, it seems to follow that we will also begin to be more creative. In a book called The Universal Traveler (Koberg and Bagnal, undated), five of these characteristics of creative people are indicated. They are:

- Belief in one's own creativity
- Freedom from pride
- Escape from habit
- Constructive discontent
- Wholeness

The following paragraphs describe how we can emulate these characteristics.

Belief in One's Own Creativity

Often I have heard people say, "Oh, I cannot do these creative things you do." More often I have heard disabled individuals say, "I can't" -- even before they have tried -- and, of course, we end up fulfilling our own prophecies.

A creative person does not have to be a great artist or inventor. Anyone is creative if they have the feeling of freedom of choice, or values -- looking at things in new ways and assuming a creative attitude about life. Believing in your own creative potential is the first step toward creativity. Say convincingly to yourself, "I feel I am a creative person." Say this everyday -- practice makes perfect.

I would like you to see and feel a creative attitude with me. In your mind, you will want to imagine someone you know that you might say of, "Gee, he/she is a creative person." Noting with great detail what they are wearing, their body attitude, their voice patterns, and how they act . . . try to get in touch with how you perceive they feel. Search for those behaviors and characteristics that have made you believe this person is creative. Remember the characteristics and feelings this person has. Closing your eyes, you will clearly see this person and begin to feel your body take on the characteristics you see in this creative person. You will assume their posture, body gestures and attitude. You will feel as they do. You will get in touch with feeling creative. Quietly reflect on this experience for a moment.

What we have just experienced is called positive projection. We have seen an image of what we would like to be and have projected ourselves into that image. This is a technique that can help us believe more strongly in our capabilities of being a creative person. The moments you assumed your envisioned person's creative attributes were moments you were yourself a creative being. Try this projection once in a while and you will feel added confidence in creative power.

Have you ever felt that creative mood just hit you, and "BOOM!" -- something fantastic is born? Creativity definitely has its moments -- and I believe these are usually spontaneous. It is pretty difficult to assign a time or place to creativity. Yet, I have found I can push myself -- or better, stimulate myself -- into a state of being creative. How? Well, I set the mood and assume a feeling of creative power and freedom. You can do this also. Here is what I do.

First, I set aside time to be by myself. It has been shown that creative people spend time alone. Solitude often promotes creativity. Given enough time, people have the chance to really explore, extend, adapt, invent, extrapolate, and create. Hurrying causes us to call upon the "easiest way" that is not new, probably not effective, probably boring and mundane, and definitely not creative.

Space is another factor I feel is important in setting the mood for creation. A feeling of being cramped is not conducive to the creative process. A space to create is important. Designating a room, closet, attic, or area for creating promotes this attribute. For example, I have an attic -- my creative storage space. I feel free to fill this space with anything I need to be creative. My living room is without furniture. This gives me the freedom to create movement, dance, meditate, lay out patterns, congest with projects, etc. We all need space to create in, store creations, keep tools of creation and to display creations. Think about your own settings, whether it be home, institution, school or community agency, and open-mindedly explore how you can set aside space for creativity.

Have you ever had the urge to create something -- but have been frustrated in the effort for lack of materials, equipment, etc.? I have. For example, when I travel I

cannot carry a great deal of things, and inevitably I would feel like drawing or sewing and would not have the things to do it with.

I have learned that creativity necessitates the opportunity to create and that I can take some precautions to ensure that I have the opportunity. I rarely go anywhere without scissors, tape, magic markers, a note pad and a few colors or paints. Why? Because when the mood strikes to create -- I am ready. I can create a drawing, a model of . . .?, a pattern for . . .?, a grant, a card, a letter, an article, or at least record a fabulous idea to develop fully later. When at home, I expand my creative opportunities by having lots of creative materials available to me. I collect junk, scraps, wood, old clothes, magazines, costumes, paint, crayons, paper, cardboard, bags, tubes, foil, string, yarn, buttons, glue, paste, glitter, ribbons, braid, etc. I know that I have the power to combine, alter, change, rearrange, and create whenever the feeling strikes. This helps me believe in my creative power.

Valuing creativity in others and ourselves and reinforcing it by verbal praise, awards, contests, and other simple gestures can help develop our beliefs in creativity. Have your eyes open to observe even the smallest thing that your staff or spouse or child does that is different, risky, and creative in nature. Honor it and make it important. You will see others begin to emulate creative behavior when it is truly valued and rewarded. I believe it an honor when people say of me, "Wow, you are creative." Now it is your turn to tell yourself this and remind others of their creativity.

Freedom from Pride

"Pride" brings to mind images that are both good and bad. Pride in my life pushes me to do the best I can, yet it also limits me. The pride that limits us from being creative is the righteous pride of self: "Oh, what will the neighbors think?" "Oh, I might fail, or be turned down." You will get the picture when you reflect on those frustrating times of over-pridefulness. Going along with the group, suppressing a thought, ignoring an idea, being bored with sameness and security, wishing you would have done . . .? All of these feelings reflect the limits of self-pride. I have learned that the worst thing most of us fear is death, and the second worst is being rejected. I have found out that death is unpredictable and that being said "no" to does not kill me. Taking risks to be creative, then, is "no sweat," as we would say in California. The more we try this theory out, the more we will believe it.

We can practice freedom from pride. I used to be a shy, quiet and fearful person. People cannot believe this, but it is true. I got into performing, dance, drama, art, theater, puppetry, competitive sports, and I gained the confidence in myself to be able to let loose, make a fool of myself and to be creative. I know now that no matter what I do, I will survive and I will still feel good about myself. It is only when I do not act on my impulses and creative drive, that I feel disappointed and un-prideful of my actions. I am gleeful to be called crazy and creative; I have a healthy pride in this. You can too.

Escape from Habit

Old habits and routines keep us in a holding pattern that prevents us from seeing creative alternatives. The tried and true old ways do not always work with special individuals, so we must leave our habits behind and escape into a more creative world. I have learned some strategies that make new ideas pop into my head -- and I would like to share them.

1. **Brainstorming**. Alone or in a group just let your ideas and work associations flow related to the topic. Record each word -- making no value judgment and limiting comments. Just get the broadest variety of phrases and words down as quickly as you can. For instance, if you are planning as part of your leisure education program a component on self-confidence, your group might brainstorm these ideas:

Pride	Voice	Drama
Body Awareness	Posture	Role-playing
Grooming	Cues	Positive experiences
Expression	Reinforcements	

Out of these brainstormed ideas, you then begin to eliminate, combine, expand, sequence and alter the concepts. Eventually your leisure education self-confidence component will be born out of the creative free flow of ideas.

2. **Creating from Poverty**. The old saying, "necessity is the mother of invention", is true. When faced with a "lack of" most people come up with something new to fill the gap. Blankets were the only play equipment I had to use when I first began a recreation program for thirty deaf-blind children. Well, I would say that is pretty impoverished conditions. That blanket became a magic carpet, a swing, a cape, a puppet stage, a soft bat, a secret tent, a parachute, a tug of rope line, a thousand

things. Yes, creating from poverty gets you out of old habits. Take one object -- anything in your house or classroom -- and challenge yourself to create a new game or activity with it. Kids like to do this too; in fact, they do it quite naturally.

3. Creating from Wealth. I have found that having "more than enough" also enhances the chances of being creative. Scrounging is a good way to create wealthy environments. I take a van and cruise around the backs of shops and small industries collecting boxes, stuffings, plastic, wood, foam, cloth, material, wire, sticks, old things of all kinds. My attic is a creative wealth of stuff. Handle it, add things to things, and manipulate things. For example, one day as I looked at a toilet seat cover, cloth, ping pong balls, socks and cardboard, I saw the jaws of a dragon come alive in the slit of the toilet cover. Folded cardboard was inserted into the circle of the cover, ping pong balls split in half added eyes, the sock covered my arm and became the neck. Five minutes, and up popped a puppet out of the wealth of junk that had surrounded me.

4. Adaptation. Change something, even just a little, and we have created something new. We adapt to make things more effective, accessible, stimulating and fun. How do you adapt? Just think "change" and apply it to the following elements of your teaching or parenting:

a. the setting
b. stimulus or pre-conditions of activity
c. equipment
d. time/day
e. transitions
f. methods of communication
g. pace/speed

h. sequence
i. motivation
j. rewards
k. post conditions
l. the activity itself

All of these factors or just a few of them can be changed and adapted. Then you have got something new, something better.

I will show how I adapted finger painting to be a more positive experience for deaf-blind children. The activity itself seemed appropriate for these young children. It is something normal children do, it provides sensory stimulation and helps to develop gross motor and fine motor skills. Yet, to me as a young child, the pleasure of seeing the beautiful colors mix around was my main motivation. These children would not be motivated by the cold, bad smelling, bad tasting paints they could not see.

Adapt: Setting: Indoors -- outdoors

Equipment: Paint -- food: peanut butter, pudding, jello, jelly, corn meal

Paper -- plastic

Post-Conditions: Clean-up -- water play with outside hose

The kids liked it. They painted, tasted and smelled it, and had a gleeful time showering off in the sprinklers.

5. Piggy-backing. This term I gave to the process I use of adding on or extending an activity to create a new one. The name came to me as I remembered myself faced with a child I could not interest in anything, so I put him on my back in a backpack for kids, like adding another caboose

to the train. The child benefitted from (a) my daily activity, (b) my warmth, (c) new perspectives, i.e., sitting up and being mobile compared to lying on a mat, and (d) new things to perceive and be stimulated by. I just extended to him these experiences by piggy-backing.

Looking at the activity of finger painting with food, my mind piggy-backed into seeing creative cookery. I asked myself how could I extend and add on to the child's presently learned activity in order to give him a valuable lifelong leisure skill that would be age and ability appropriate. I searched for something that could be cooked, baked or prepared using basic motor skills such as grabbing, pouring, squashing, mixing and stirring. I also looked at the things that were prepared primarily with bare hands. No-bake cookies were my first idea and I piggy-backed from that idea as bread baking and bread dough sculpture came to mind. The kids and I progressed from making no-bake cookies out of peanut butter, honey, and milk powder rolled in wheat germ, to biscuit mix rolls to raised bread to bread dough sculptures that we preserved with shellac. You can even piggy-back from a simple activ ity to an adult lifelong hobby.

6. Choicing, Ordering or Re-Ordering. Ever been just stumped? Faced with a situation, most people believe that there are only two answers: A or B. The fact is there are always at least five possibilities and usually unlimited alternatives to any situation. If you open yourself up to the potential of choices and the ordering or re-ordering of them, you will come up with some creative alternatives. For any given situation remember you can answer it by choosing A; B; A and B; neither A nor B; !A and !B; B then A; etc.

7. Renaming. Adding an adjective or verb to the idea or activity you are trying to recreate helps get the creativity flowing. Try a renaming exercise with me related to a social dance class:

RENAMING EXPERIENCE
SOCIAL DANCE CLASS

Adjective or Verb List	New Idea That Comes to Mind
1. Modern	Disco
2. Old	Ballroom Dance
3. Formal	Sweetheart Prom
4. Structure	Lessons and instructor format
5. Unstructure	Drop-in boogy time
6. Adapt	Wheelchair disco
7. Foreign	Folk dance
8. American	Square dance
9. Outside	Moonlight lawn dance
10. Inside	Gym sock-hop
11. Remember	Videotape, pictures
12. Combine	Dinner/Dance
13. Separate	Teach social etiquette, dressing party planning and dancing separately
14. Simplify	Aerobic dance in seated position, non-locomotor movements
15. Complicate	Take a trip to another city to go dancing
16. Spectate	Watch a dance performance
17. Add on	Roller skate disco
18. Take away	Expressive dance, no music

8. Getting Out of Town. Breaking old habits can be enhanced to looking at situations from new perspectives. When I feel empty of creative ideas, I try various approaches to "getting out of town." They are:

- Conferences/workshops
- Travel
- Talking to other people a little less involved in the situation
- Searching through the library

- Meditation -- mind travel to new subconscious worlds
- Taking a break -- just putting it down for a while often renews my energy for creating something

Constructive Discontent

People that are always satisfied with the same old thing, status quo, just plain "seagull" existence, never make waves and are not generally creative. Looking at life with an attitude of "how can I make it better" is what is called constructive discontent. All of the aspects of an activity listed under the section on adaptation can be changed for the better when looked at with constructive discontent. Creative people make a few waves and search for new and better ways of doing things.

Wholeness

Finally, creative people have a wholeness about them. They successfully balance thinking and feeling, moving and quietness, taking and giving, right and left brain activity -- they have a sense of centeredness. For you to be a creative person you must find new and energizing input just for you. New places, people and activities that give you joy and stimulation are vital ingredients to your wholeness. Work-a-holics have no time to create. Developing wholeness will reinforce the other creative characteristics of belief in your creativity, freedom from pride, escape from habit, constructive discontent.

List of References

Koberg, D. and Bagnall, J. Universal Traveler: A Soft Systems Guide to Creativity. Los Altos, CA: W. Kaufman, Inc., One First Street, 94022 (undated).

ATTRIBUTION THEORY IN THERAPEUTIC RECREATION

Alison Voight*

Introduction

In a general sense, the purpose of all human service delivery systems, including the field of recreation, is to facilitate human happiness and strive to improve the quality of life (Edginton, et al., 1980). This is also particularly true for those professionals in recreation working with disabled populations.

Recreational professionals working with disabled populations face certain barriers which often inhibit or render their clients incapable of experiencing fulfilling leisure activities. Whether these barriers be environmental, economical, psychological, sociological, or physical, the service of recreation for special populations is especially concerned with facilitating satisfaction, independent leisure functioning, and improving one's life to its fullest potential (Kraus, 1978; Gunn and Peterson, 1978).

In using recreation and leisure activities as a means of attaining the goal of human happiness and satisfaction,

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the most critical barriers recreationists will encounter with clients are social and psychological in nature. Regardless of the setting, population, or disability with which they are working, recreationists must aid the client in overcoming psychological problems or detrimental attitudes he may have about himself and/or others. For example, an individual confined to a wheelchair may be able to participate in a great many activities depending upon his attitude and willingness to try, as well as the support he receives from others. On the other hand, a person who has no physical limitations may, because of feelings of extreme inadequacy, apprehension or incompetence, be very unwilling to participate in any kind of activity whatsoever. So while technical or physical difficulties can at times be lessened, overcoming socio-psychological restraints should be the most crucial concern to recreation professionals working with special populations. Therefore, the primary task of recreationists is to improve clients' psychological and social well-being (Iso-Ahola, 1980).

Attribution Theory

Before recreationists can attempt to improve a client's psychological and social well-being, they must first have a sound understanding of how that client is oriented, both socially and psychologically. In other words, how does that client perceive himself and his behavior, and how does he think others perceive him? Does the client feel that other factors (i.e., chance, luck, etc.) or other persons are responsible for his behavior and consequential successes or failures in life? This conceptual analysis of causality -- examining why the events in one's life turn out the way they do, and how we, as individuals, may have

influenced these events -- is defined as attribution theory (Dixon, 1979).

Attribution theory attempts to explain the natural inclination and desire of many to understand human behavior. It also "describes the processes by which causal explanations are made. It deals with the principles of assigning causality of behavior to the qualities of a client (dispositional attribution), to the situational factors (environmental attribution), and with the implications of these attributions for one's future behavior" (Iso-Ahola, 1980).

An individual who is dispositionally attributed perceives her behavior to be under her own control, which reflects her abilities, competencies, and efforts. An individual who is environmentally or situationally attributed, feels that she lacks personal control over the events in her life, and that they are a result of factors or forces outside herself.

Herein lies the challenge to recreationists dealing with special populations. That is, they must strive to develop positive dispositional attributions in their clients. In other words, they must provide recreational opportunities that will enable the client to feel good about himself, and instill feelings that his success in an activity was due to his abilities and efforts, and not to outside factors such as luck (Dixon, 1979). Consequently, a client is in a more desirable state when he is positively dispositionally attributed as opposed to being in a dependent, situationally attributed one.

Attribution Therapy for Special Populations

Irrespective of the type of population recreationists are working with, they must begin to develop programs and

programming techniques that not only help to determine the psychological orientation, or attributions of their clients, but provide recreational and leisure activities that will help to improve them as well. Merely providing a checklist of activities that clients may choose from is insufficient toward easing illness and disability and improving the quality of a client's life. Many recreationists are working in institutional or highly structured settings where the client is usually in a dependent state and the focus of recreation is therapy and rehabilitation (Gunn and Peterson, 1978). It is at this point, where the client may have low self-esteem and lack feelings of being in control, that recreational activities can have an extremely beneficial and therapeutic effect. But only if the activities programmed are aimed at improving certain dispositional or situational attributions relevant to a particular client's status. For instance, an individual who is depressed may benefit more from being by herself and engaged in an activity that she is particularly skilled or successful at, than by being asked to participate in a card game or another similar type of social activity. Or the opposite may be true. Frequently, a person who is depressed may need to be socially involved with others in order to gain back feelings of security and self-esteem, rather than being alone. In either case, it becomes clear that recreationists cannot just indiscriminately program recreation activities for whatever population they may be working with, hoping that the client will somehow improve. As professionals, recreationists should have a clear understanding of why they are doing what they're doing. Seppo E. Iso-Ahola states several primary concerns relative to recreationists and special populations:

> The most critical challenge to the therapist is a client who views the world as uncontrollable and infers personal helplessness to do most anything. It is in this process of increasing the client's perceived control and avoiding a feeling helplessness that recreation activities are used as a treatment modality. Participation in leisure activities is therapeutic to the extent that it enables a person to make attributions of leisure behavior to personal capabilities . . . . It is then clear that simply providing recreation services to special populations is psychologically insufficient. What is needed is attribution therapy aimed at conquering helplessness and improving self-concept (Iso-Ahola, 1980).

Programming Based on Attribution Theory

The recreationist, at this point, may feel somewhat overwhelmed with the concept of programming activities based on attribution theory. However, one needn't be a psychologist or psychiatrist to understand the basic implications this theory holds for programming recreation for special populations. When the recreationist has conceptualized its potentialities, she can begin the process of developing a program particularly suited to her setting and clientele.

The first step the recreationist must keep in mind is the expected behavioral outcomes the client is to experience via recreational activities. These include physical, psychological, and social outcomes (Edginton, et al., 1980). But most clients in hospitalized or structured settings today have reduced periods of stay (Bloom, 1979). They may range from two weeks to two months or more, depending on the nature of the illnes. As a consequence, the recreationist may feel she has little time to accomplish anything of value in terms of goals and objectives and behavioral outcomes. This presents an even greater need for

determining a client's causal attributions as soon as he or she has been admitted.

The second step in programming should be establishing the resources and recreational activities that one has available. In other words, set up a program of activity areas that the client will be working from. Several areas might include physical activities, arts and crafts, and cultural events.

The third step is to combine the first two mentioned above, establishing behavioral outcomes and activity areas, and then develop an instrument that will help assess the causal attributions of the client. These steps will aid in determining what will be the most effective type of recreational programming to implement. It is the author's contention that asking questions regarding how clients feel about certain recreational activities rather than simply what they like, will be a starting point for determining their causal attributions. The questions asked should reflect certain expected behavioral outcomes and objectives specifically designed by the recreationist for her particular population of clients.

Figure 1 (see Appendix) is an example of an Activity Assessment Inventory, designed by the author for use in a psychiatric facility. The activity categories are based on five actual program areas used in a therapeutic recreation department for an acute inpatient psychiatric setting. The client is to designate with a check mark the category(s) that most accurately reflects his feelings about that particular question. The reader will notice that in addition to basing questions on available recreational resources to help determine causal attributions, there is an area for the client and the recreationist to establish long- and

short-term objectives, together, for the duration of the client's involvement in the recreation program.

Advantages of Attribution Therapy-Based Programming

Asking questions about how clients feel regarding different recreational activities allows the recreationist an opportunity to begin her treatment plan as soon as the questionnaire has been completed. In this respect, the treatment can be designed to meet the needs of the client, rather than having the client try to fit whatever existing program plans have been established.

In addition to a more rapid assessment of a client's attributions, this type of approach provides the opportunity for the recreationist and the client to work together toward achieving common goals and objectives through recreational activities. The client is being programmed with, not for. He knows what is expected of him, and what he has agreed to work on. This not only increases the client's perception of control over his environment, but because he has input into his treatment plan he is more likely to be cooperative and willing to try, and sense a greater degree of freedom (Neulinger, 1981). This in turn should help facilitate a more rapid recovery toward independent leisure functioning.

The most important aspect of the Activity Assessment Inventory is the fact that it asks questions to determine causal attributions of recreational behavior based on the actual activities available at a particular facility. There is no point in distributing a hundred-item checklist of desired recreational activities to clients if the majority are not available to them. The recreationist can realistically begin her treatment based on the resources she

has immediately available. Treatment becomes more manageable and productive when one knows what she has to work with.

Disadvantages of Attribution Therapy-Based Programming

When using the Activity Assessment Inventory, or a similar means of assessing causal attributions of clients, the clients must answer the questions as honestly as possible. If the client, for whatever reason, is untrusting or fearful of disclosing personal feelings about himself, the recreationist will not receive a representative view of how that client is dispositionally attributed. This in turn will interfere with a productive rehabilitative process.

Another disadvantage is that assessing attributions based on recreational activities available in one's setting may provide too limited a spectrum. The client is fairly resigned to using only those activities designated for him by the recreationist's program areas.

Finally, there is still much research needed to discover how recreational activities, and under what conditions, can best improve causal attributions of clients (Iso-Ahola, 1980). In addition, recreationists need to gain a greater knowledge of attribution theory, and its implications and potentialities of programming for all special populations in a variety of recreation settings.

Summary

Recreationists today must face the realization that merely providing a selection of recreational activities to special populations is insufficient toward attaining the goal of the field of recreation and leisure services. The

most critical barriers recreationists encounter in attempting to achieve this goal -- the increased satisfaction, independent leisure functioning, and the improvement of the quality of human life -- are social and psychological barriers. It is the primary purpose of recreationists working with disabled populations not just to provide recreational activities, but to provide recreational activities and experiences aimed at improving a client's socio-psychological well-being. Before recreationists can attempt this challenge, they must have a clear understanding of how the client is psychologically oriented -- or put another way, causally attributed. The causal attributions maintained by clients, whether they be dispositional or situational, will determine not only how they will receive and benefit from certain recreational activities, but also provide a starting point for programming plans in the process of rehabilitation.

Appendix

Fig. 1--Activity Assessment Inventory

Directions: The following questions are asked to better understand, not only which recreational activities you enjoy, but how you feel while participating in them. Each letter represents a category of recreational activities available at this facility. Please place a check next to the letter that best describes your feelings. You may choose more than one category or write in something that is not listed.

A. Arts and Crafts

Decoupage
Holiday Decorations
Mobiles

B. Cultural

Plays
Art Exhibits
Musical Concerts

A. Arts and Crafts (cont.)

Painting, Drawing, Coloring
Tile ash trays
Reed basket weaving
Woodworking (table size objects)
Coppor Tooling
Leather work (small objects)

C. Physical Activities

Walks
Jogging
Punching Bag
Bicycle Riding
Yoga/Exercises
Kick Ball
Volleyball
Lifting Weights
Basketball
Swimming (summer only)

G. None

B. Cultural (cont.)

Sing-a-longs

D. Indoor Games

Bingo
Cards
Table games ("Sorry", Monopoly, Aggravation, Scrabble)
Pool
Tournaments

F. Individual Games

Reading
Sewing
Gardening
Cooking

H. Other

Any activity not listed

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1. Which of the following activities makes you feel comfortable and in control?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

2. Which of the following activities do you feel particularly skilled in?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

3. Which of the following activities makes you feel confident and self-assured?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

4. Which of the following activities do you enjoy doing with other people?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

5. Which of the following activities do you prefer to do along?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

6. Which of the following activities makes you feel uneasy or uncomfortable?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

7. Which of the following activities makes you feel bored?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

8. Which of the following activities really makes you feel excited and happy?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

9. which of the following activities do you like to participate in the most?

   A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

10. Which of the following activities have you never tried because of the fear that you would do poorly in them?

    A.___ B.___ C.___ D.___ E.___ F.___ G.___ H. other___

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11. Short Term Objective

    Plan:

Date _____ Patient Signature_____

12. Long Term Objective

Plan:

Date _____ Patient Signature _____

List of References

Bloom, B. L. Community Mental Health. Monterey, CA: Brooks/Cole Publishing Co., 1977.

Dixon, J. T. "The Implications of Attribution Therapy for Therapeutic Recreation Service." Therapeutic Recreation Journal, Vol. 13 , No. 1 (1979), 3-11.

Edginton, C. R., Compton, D. M., and Hanson, C. J. Recreation and Leisure Programming: A Guide for the Professional. Philadelphia, PA: Saunders College, 1980.

Gunn, S. L. and Peterson, C. A. Therapeutic Recreation Program Design: Principles and Procedures. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1978.

Iso-Ahola, S. E. The Social Psychology of Leisure and Recreation. Dubuque, IA: Wm. C. Brown Co. Publishers, 1980.

Kraus, R. Therapeutic Recreation Service: Principles and Practices. Philadelphia, PA: W. B. Saunders Co., 1980.

Neulinger, J. To Leisure: An Introduction. Boston, MA: Allyn and Bacon, Inc., 1981.

INSTRUCTION IN INTERPERSONAL RELATIONSHIP SKILLS: AN EVALUATIVE RESEARCH STUDY

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Introduction

Interpersonal relationship skills are today considered an essential competency for therapeutic recreation personnel. A successful interpersonal relationship is based on patience, understanding, sensitivity, and commitment to others, and is necessary for communication to exist between therapeutic recreation specialists and clients. According to Brill (1978), "the major initial task of human service workers is to develop and maintain communication with their clients."

Therapeutic recreation is one of the human services, or "helping professions", where the conditions of genuineness, empathy, and respect must exist between helper and helpee. The higher the therapeutic recreation specialist's level of skill in communication, the greater is his or her ability to create these conditions, and to perform as a helping

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professional. These conditions do not necessarily occur automatically, but must be cultivated by the trained helper.

Sensitivity training has been recommended for recreation professionals, in order to develop self-awareness and to improve leadership and communication skills (Schwartz, 1970). A training program for recreation leaders in a rehabilitation facility was effective in increasing trainees' overall ability to communicate effectively within a helping relationship (Collingwood, 1972). The participants suggested that training in communication skills be given at the university level or as part of an agency inservice program. It was felt that this training could increase the potential of therapeutic recreation specialists to function as change agents. James (1975) has taken the position that "human relations training . . . be given to all leaders who deliver recreation services to the public" because there has been little effort to provide recreators with the skills needed to contend with the human problems they encounter in their work.

The importance of free and open communication between subordinate and manager, in order to maintain a productive and satisfying work atmosphere, has been noted (Austin, 1977). A successful leader respects each individual's sense of personal worth, reinforces confidence, and works toward initiative and self-actualization (Sessoms and Stevenson, 1981). In therapeutic recreation, effective leadership often appears to correlate most highly with the quality of interpersonal relationships established between staff members and clients (Gunn and Peterson, 1978).

One human relations training program for recreation leaders received overwhelmingly positive evaluative data and participants' reports. Desire for a more lengthy

training program was expressed by trainees. Earning credit through a university for such training was suggested (Smith and Futch, 1978).

Field Supervisors' Priority for Competency

In a study of therapeutic recreation personnel who had served as field supervisors for therapeutic recreation students, the competency area, "Interpersonal Relationship", defined as "supervisor maintains a relationship with the student that is characterized by sharing, caring, and emotional support", was rated the most needed of nine areas for supervisors. The individual competency ranked third most needed of sixty-nine competencies was "demonstrating the ability to work closely with another adult without feeling threatened by their questions, criticisms, ideas, or suggestions" (Kunstler, 1980). It is clear from this review that the development of interpersonal relationship skills is critical to success in the fulfillment of a variety of professional roles: leader, student supervisor, and manager. Although including this training as part of a regular curriculum has been recommended, it has not been reported.

Methods

In an undergraduate therapeutic recreation curriculum at a large mid-western university, junior-level majors in therapeutic recreation enrolled in the course, "Techniques in Therapeutic Recreation". The majority of the 104 subjects were female, between 19 and 21 years of age. One-third of this course was devoted to the teaching and learning of the interpersonal relationship skills of attending, clarifying, reflecting, giving and receiving feedback,

using silence, reinforcing, goal-setting, summarizing, and non-verbal communication. Student learning activities included lecture-discussion on the helping relationship and counseling behaviors, and readings and selected interpersonal relations exercises from the book, Counseling Strategies and Objectives. These exercises included working alone and in dyads to experiment with the skills of using silence, opening and terminating an interview, responding to affective and cognitive content, using reflecting and summarizing techniques, and clarifying and reflecting feelings. The book was written for use by trainees from a variety of professions, including recreation specialists, who were about to begin their first contacts with clients in a practicum field experience, or job settings (Hackney and Cormier, 1979). Students in the class were also given an opportunity to apply these skills by tape-recording an interview with a person not enrolled in the class. These tapes were later critiqued by a classmate.

The IRRS. To test the effectiveness of this training on four successive classes, from 1976-1979, Hipples' Interpersonal Relationship Rating Scale (IRRS) was administered on a pre- and post-test basis. The IRRS is brief, easily understood, and may be self-administered. It consists of 24 items on which the subject rates him/herself on a scale of one (a negative rating) to seven (the highest positive rating). The following are examples of these items: ability to listen to others in an understanding way; awareness of the feelings of others; willingness to discuss his feelings and emotions with others; and tendency to seek close personal relationships with others. Although originated for use in human relations laboratories, the scale appeared to have promise for application in educational

settings as well. It would appear that students undergoing training in interpersonal relations would experience significant increases in their IRRS scores.

Results

All class members were administered the IRRS during the first class session of the semester (the pre-test) and again following the unit of instruction on interpersonal relationship skills (the post-test). A nonparametric test, the Wilcoxon Signed-Ranks Test, was employed on the data. This test allowed comparison of distributions of the pre-test and post-test scores of the student subjects.

Table 1 shows the percentage of subjects who increased their scores and the average number of points those scores increased for the four classes tested. For all four classes the results were significant at below the .01 level.

TABLE 1

Percentage of Students Whose Scores Increased and Average Number of Points Increased

Class	Total # of Subjects in Class	% of Subjects Whose Scores Increased	Average # of Points Increased
'76	21	81%	9.9
'77	23	74%	8.5
'78	32	81%	11.3
'79	22	79%	13.1

Table 2 shows the results of an item analysis conducted on the last two years of data. Two items were more frequently given low ratings (1, 2, or 3 on the 7-point scale), over any other items on the pre- and post-tests combined. These items were: No. 10: "reactions to conflicts and antagonism from others", and No. 22: "level of anger expression."

As can be seen from Table 2, items 9, 12, and 23 received a much smaller number of low ratings, than items 10 and 22. All other items received less than six low ratings.

TABLE 2

Items Most Frequently Given Low Ratings

	Item	# of Ratings	
		Class of '78	Class of '79
No. 10	Reaction to conflict and antagonism from others	20	14
No. 22	Level of anger expression	17	21
No. 9	Reaction to the opposing opinions of others	10	4
No. 12	Willingness to discuss his feelings and emotions with others	7	6
No. 23	Clarity in expressing thoughts	2	6

Summary

The results of this study lead the authors to conclude that classroom training in interpersonal relationship skills can have a significant impact on the self-ratings of

undergraduate therapeutic recreation majors, as measured on a scale designed to measure skill level in this area. It was also found that students perceived themselves lacking in the skills needed to constructively express their own anger and to respond to hostility from others.

Training in interpersonal skills is imperative for therapeutic recreation specialists, and the need for this training has been established. It is the interaction between the client/consumer and the specialist that transforms an activity into an experience that is meaningful to, and capable of producing change in, the participant. This interpersonal relationship is the "therapeutic" component of recreation, and contributes much to the rationale and philosophy underlying therapeutic recreation services. Training in these skills should be included in all therapeutic recreation curricula. Special attention should be paid to teaching students how to express and respond to angry and hostile feelings. The effects of this training should be tested and reported in order to further the development of therapeutic recreation education and the profession. It is no longer enough to rely on instinct; qualified instruction in now available and essential in the preparation of students to fulfill their professional roles.

List of References

Austin, D. "A Humanistic Approach to Management and Motivation." Therapeutic Recreation Journal, Vol. 11, No. 3 (1977), 123-127.

Brill, N. Working With People - The Helping Process. New York, NY: J. B. Lippincott Co., 1978.

Collingwood, T. "The Recreation Leader as a Therapeutic Agent." Therapeutic Recreation Journal, Vol. 6, No. 4 (1972).

Gunn, S. and Peterson, C. Therapeutic Recreation Program Design. Englewood Cliffs, NJ: Prentice-Hall, 1978.

Hackney, H. and Cormier, L.S. Counseling Strategies and Objectives. 2nd Edition. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1973.

James, A. "Human Relations Training for Recreation Leaders." Therapeutic Recreation Journal, Vol. 9, No. 1 (1975).

Kunstler, R. Competencies for Therapeutic Recreation Field Experience Site Supervisors. Unpublished doctoral dissertation, Indiana University, 1980.

Schwartz, R. "Sensitivity Training and Its Relationship to Recreation Professionals." Therapeutic Recreation Journal, Vol. 4, No. 1 (1970).

Sessoms, H. Douglas and Stevenson, J. L. Leadership and Group Dynamics in Recreation Services. Boston, MA: Allyn and Bacon, Inc., 1981.

Smith, P. and Futch, J. "A Human Relations Training Program for Recreation Leaders." Therapeutic Recreation Journal, Vol. 12, No. 1 (1978).

AN ANALYSIS OF AN EASTER SEAL CAMP'S PEPCEPTIONS OF ORGANIZATIONAL CHARACTERISTICS, ACCEPTANCE OF SELF, ACCEPTANCE OF OTHERS AND CONFLICT CHARACTERISTICS

Jeffrey Glick*

Introduction

Organized Camping. Within the unbrella of leisure service delivery systems, the organized camping movement has provided opportunities for human social interactions to be guided in a controlled environment (Feldman, 1976). Yet, the benefits that may accrue to an individual as a result of social and environmental interactions within the organized camp setting has remained unsupported by research evidence (Carlson, 1975; Lowry, 1974; Redl, 1974; Wittekin, 1974.) The camping literature suggests that an individual can grow in terms of self-development, sense of belonging, avocational skill development, friendship formation, and appreciation of nature (Carlson, 1975; Rodney and Ford, 1971). Studies by Kreiger (1970), Johnson (1970), Duke

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(1968), Davidson (1965), Beker (1959), and Barber (1957) resulted in evidence that is contradictory as to the benefits of the organized camping experience.

Of those studies completed, much attention has been focused on the benefits of the camping experience for the service recipients (campers) with virtually no attention to the effects of organized camping upon staff members or the carry-over from staff members to campers and vice versa. It has been hypothesized that the camp staff is considered the essential element in the achievement of a particular camp's goals (Myers, 1980; Myers, 1978; Leadley, 1976; Doty, 1960). The importance of staff is sublimated by the concept that there must be an atmosphere established for the staff members to function effectively.

> It must be recognized that the implementation of the camp objectives does depend upon the ability of the staff, and the ability of the staff is often directly related to the administration of the camp and to the efficiency of the organization (Rodney & Ford, 1971, p. 21).

If an organized camp can be characterized as being a laboratory for democratic practices with ideals of freedom, equality and fellowship, then the administrative avenues which facilitate participation, responsibility, accountability and decision-making must be consistent with democratic ideals (Boorman, 1941). Precisely how an organized camp develops its administrative avenues and the effects upon staff members has yet to be reported in the research literature (Myers, 1976).

Organized Camping and Special Populations. Organized camping represents a leisure service delivery system in which factors such as attitudinal and physical accessibility, equipment design, transportation and economics have been controlled to permit participative opportunities to

exist for people with disabilities. Studies into the effects of camping programs with special populations have yielded mixed results. Investigations by Sessoms, et al. (1978), Glick (1978), and Holden (1969) revealed significant positive personality changes in campers with disabilities, while investigations by McGuire (1976), Rappaport (1974), Dibner and Dibner (1973), Lefebrve (1972), and Herzog (1956) resulted in no or slightly negative changes in personality and physical fitness variables.

A research trend has begun to develop within organized camping and special populations that places more attention on camp staff. Studies by Sessoms et al. (1978), Ross (1971), and Randolph (1956) have focused on the importance of pre-camp training and what is needed to prepare staff members for a quality experience. Studies by Austin and Lewko (1979) and Lewko, et al. (1978) have examined staff communication patterns and attitude formations in relationship to camper performance. These studies have begun to address specific areas of professional development in which information is needed.

> In recent years there has been an increasing demand for specific information, professional guidance, and direct assistance to help personnel initiate activities, upgrade programs, answer questions and attack programs which create roadblocks to progress in various aspects of physical education and recreational programs for handicapped children (BEH, 1969, p. 1).

The organized camp environment provides an opportunity to explore the development of skills and attitudes of individuals working, living, and playing with people with disabilities.

> . . . we must know more than we now know about the range of factors that have influenced current personnel preparation and employment practices, the effects of recent training efforts and the

essential performance characteristics for particular job tasks and service and training approaches (Meyer, 1980, p. 117).

Statement of the Problem. The purpose of this study is to investigate the perceptions of a summer residential camp staff concerning organizational characteristics, acceptance of self, acceptance of others, and conflict characteristics as well as the relationships between the above mentioned variables. More specifically, the following questions were addressed:

1. Does the staff perceptions of organizational characteristics change from pre- to post-testing periods?
2. Does the staff member's acceptance of self change from pre- to post-testing periods?
3. Does the staff member's acceptance of others change from pre- to post-testing periods?
4. Does the staff member's perception of conflict characteristics change from pre- to post-testing periods?
5. Are there relationships at the pre-testing period between staff members' perceptions of organizational characteristics climate, acceptance of self, acceptance of others and conflict characteristics?
6. Are there relationships at the post-testing period between staff members' perceptions of organizational characteristics climate, acceptance of self, acceptance of others, and conflict characteristics?

Method

Subjects of Study. Twenty-seven first-year staff members of Camp Daddy Allen were subjects of this study during the 1980 summer season. Camp Daddy Allen has been operated by the Easter Seal Society of Pennsylvania since 1941. The focus of the program is to provide socio-recreational opportunities for people with neuro-orthopedic disabilities ranging in ages from six through eighty-five.

Data Collection. Data concerning the perceptions of staff members (n=27) were collected on a pre- and post-test basis. During the pre-camp training period, two sessions were held to collect data. On the second day of pre-camp, an introductory letter explaining anonymity and confidentiality as well as the research procedures was given to each staff member. A coding indentification sheet and the Berger Questionnaire were then administered. The responses were collected and held by the researcher. On the fifth and last day of pre-camp training, a staff meeting was held to administer the Profile of Organizational Characteristics Form SLM and the Profile of Conflict Characteristics. Code numbers were retained by staff from the previous testing and the completed questionnaires were collected by the researcher.

Seven weeks after the pre-camp training period a post-testing session was conducted. An afternoon staff meeting was convened as all three testing instruments were administered and coded with the original coding number of the staff member.

Instrumentation. The instruments used in this study of organized summer residential camping as follows:

1. **Profile of Organizational Characteristics Form SLM**, which is a sixteen-item questionnaire measuring six administrative processes: leadership (3), communication (4), motivation (3), decision-making (2), goals (2), and control (2). An eight-point Likert rating scale was used to indicate the typology of organizational climate. A "1" or "2" indicated an authoritarian climate while a "7" or "8" indicated a democratic climate. Two subscales were featured in which an ideal and real perception of each variable was obtained.

2. **Berger Questionnaire**, which is a fifty-four item inventory measuring acceptance of self and others. A five-point Likert scale ranging from "not true of myself" to "true of myself" was used. Thirty-six of the items were summated to obtain an acceptance-of-self score. The higher the total, the greater one's acceptance of self. The remaining twenty-eight items, when summated, reflected an acceptance-of-others score.

3. **Profile of Conflict Characteristics**, which is a fifteen-item questionnaire developed to ascertain the nature and extent of conflict by Rensis Likert. Each item was responded to on an eight-point Likert scale. A "1" or "2" reflected an organization that is resolving conflict in the manner of an authoritarian organization, while a "7" or "8" reflected an organization that is resolving conflict in a democratic manner.

Data Treatment. The following statistical procedures were used in the analyses of the data: correlated t-tests, Pearson product correlations, and multiple regression analysis. All tests of significance were conducted at the $p<.05$ level.

Summary of Findings

Six research questions were addressed in the analysis of first-year Daddy Allen staff (n=27) perceptions of

organizational characteristics, acceptance of self, acceptance of others, and conflict characteristics. As shown in Tables 1 and 2 (see Appendix), the mean and standard deviation scores for both the real and ideal Profile of Organizational Characteristics (POOC) were calculated at pre- and post-test periods. Significant differences were obtained between the real pre- and post-perceptions for each of the administrative processes (Table 1). The change in the scores indicates that the organizational characteristics were initially perceived as those of a consultative organization, and at post-testing those of a hybrid benevolent-authoritarian/consultative organization.

Significant differences were obtained between the real and ideal perceptions of organizational characteristics at both test periods (Table 2). At both test periods, an ideal organization as having a hybrid of consultative/democratic administrative processes was preferred. The significant differences between the real and ideal perceptions of each of the administrative processes at both test periods is indicative of a discrepancy between an organizational climate that is consultative (pre) and benevolent-authoritarian/consultative (post) and one that should have administrative processes that are of a consultative-democratic nature.

As is shown in Tables 3 and 4 (see Appendix), no significant differences were obtained between the staff members' mean Acceptance of Self (AOS) and Acceptance of Others (AOO) scores at both test periods.

The mean AOS scores (145.926 and 146.963) and mean AOO scores (110.741 and 109.000) are within the normative ranges as reported by Berger (1952) for college students.

Significant differences were obtained in the staff perceptions of conflict characteristics from pre- to post-

test periods. As shown in Table 5 (see Appendix), conflict characteristics as perceived by staff had changed from that of a consultative organization (pre) to those of a hybrid benevolent-authoritarian/consultative organization (post).

Moderate pre-test relationships were obtained between the staffs' perceptions of administrative processes, acceptance of self, acceptance of others and conflict characteristics as shown in Table 6 (see Appendix). A stepwise regression analysis revealed that 29.24 percent of the variance in conflict characteristics was explained by the variance in administrative processes, acceptance of self, and acceptance of others, which was not significant at the .05 level of signficance.

As Tables 7 and 8 (see Appendix) indicate, strong post-test relationships were obtained between the staff's perceptions of administrative processes, acceptance of self, acceptance of others and conflict characteristics. The post-test Pearson product correlation matrix (Table 7) contains more statistically significant correlations than the pre-test matrix (Table 6). A stepwise regression analysis (Table 8) revealed that a significant total of 79.852 percent of the variance in conflict characteristics can be explained by the cumulative effect of the eight independent variables.

The real decision-making administrative process had the highest correlation with conflict characteristics (.8362) and was entered first; 69.92 percent of the variance in the perceptions of conflict characteristics can be explained by decision-making processes.

Discussion and Implications

The perceptions of first-year staff confirms that Camp Daddy Allen was partially achieving a democratic-decentralized camping environment. In four of the six administrative processes, the organizational climate was perceived as consultative and did not show a meaningful change from pre- to post-test periods. Within the communication and decision processes, a change was perceived as the camp was thought to move from a consultative climate to that of a benevolent-authoritarian climate. Part of this change may be accounted for by the influence of staff burnout/fatigue by the end of camp. An alternative explanation which supports the theories of Boorman (1941) is that staff did not have sufficient skill proficiency in the areas of decision-making and communication to accept the responsibilities and demands of democratic living.

This explanation is further supported by the ideal staff perceptions of a democratic camp organizational climate. The researcher proposes that the abilities, skills, and readiness of first-year staff were not developed to realize the ideal perceptions. Many of the staff typify individuals who have not had the opportunity to develop democratic living skills in their families and educational institutions at primary, secondary, and higher educational levels. When faced with decentralized camp living, the consequences of individual and community responsibility then clash with lifestyles and preferences that have not had to take into account risk management, accountability and group decision-making.

The profiling of conflict characteristics further explores the dynamics operating in the camp environment. The significant change perceived by staff in terms of

conflict suggests that there were unresolved differences among staff. The ways in which Daddy Allen staff perceived their handling of interpersonal and situational conflict are indicative of organizations not utilizing human resources to the utmost (Hershey and Blanchard, 1977; Likert and Likert, 1976). One explanation for the perceived change, is that the period of pre-camp emphasized cooperative efforts of the staff to learn skills, know and trust one another, and prepare camp for opening. If conflict existed, it was minimal as the staff directed their initial efforts toward the anticipation of the summer season. By the end of the summer enough time and interaction had elapsed so that differences between people were known and being dealt with. The manner in which conflict was dealt with is subject to further inquiry.

Varied Staff Views. As the study variables were examined, the lack of relationships between staff perceptions suggest that a mixture of apprehension, unrealistic expectations, lack of knowledge, and a lack of realistic encounters were operating during pre-camp training. By the post-test period, the strength of the relationships between administrative processes and 1) acceptance of others, and 2) conflict characteristics provides evidence to support the importance of camp administration held by Rodney and Ford (1971) and Boorman (1941). In particular, the decision-making processes had the strongest relationship to conflict characteristics. The decentralized programming thrust at Daddy Allen whereby staff had the opportunity to share with campers day-to-day decision opportunities, establish program goals, and participate in camp governance through councils and staff committees probably induced the

opportunities in which staff's skills were not adequate to meet the responsibilities. When conflict arises and is not used constructively, there is a decrease in the ability of a group to meet its goals (Gibb and Gibb, 1978; Johnson and Johnson, 1976). Thus, the implications of a camp staff not being able to resolve conflict would lead to a lessening of goal attainment, which might affect campers as well.

Summary

The necessity for obtaining further information about the development of quality educational and training programs for human service professionals is known (Meyers, 1980). The data in this study suggests that there are several skill areas upon which pre-professional preparation programs can focus. First, a focusing upon the awareness and attitude development necessary for democratic living and responsibilities. Secondly, the development of curricula that focus on the decision-making and communication skill areas. Lastly, the development of curricula opportunities that enable people to practice and develop skills in prevention of conflict and/or the creative resolution of conflict.

Within the limitations of this study, the following conclusions were reached:

1. The organized summer residential camp for people with disabilities facilitates the growth and development of staff as evidenced by the normative staff perceptions of self-acceptance and acceptance of others.

2. The camp administrative processes influence the cohesiveness of staff as a function of resolving conflict. It has been indicated that a staff that develops and uses participative skills in decision and communication areas will be able to use conflict positively.

3. Staff members must develop skills of democratic living as evidenced by the discrepancy between ideal and real perceptions of camp organization.

Recommendations for Research

Replication studies should be conducted at a variety of camps to provide information as to patterns of camp administration. A follow-up testing period should be included to neutralize the influence of fatigue and end-of-camp feelings. Other studies should concentrate on the development of a taxonomy to be used in comparison studies of organizational development and administrative practices. Further studies should focus on developing criteria for staff effectiveness, which could then be related to perceptions of organizational climate, conflict characteristics and camper satisfaction and skill development.

Appendix

TABLE 1

T-Test of Differences in Mean POCC Real Scores From Pre- to Post-Test Periods (n = 27)

Organizational Characteristics	PRE			POST			t Value	Total Signif Level
	Mean	Std Err	Std Dev	Mean	Std Err	Std Dev		
Total POCC (16 items)	99.667	2.098	10.902	81.481	1.942	15.288	6.23	.001
Leadership (3 items)	6.358	.138	.716	5.259	.232	.203	4.38	.001
Item 1	6.630	.214	1.115	5.590	.240	1.238		
Item 2	5.815	.245	1.272	4.704	.357			
Item 3	6.630	.194	1.006	5.481	.279	1.451		
Motivation (3 items)	6.778	.163	.847	5.580	.231	1.200	5.64	.001
Item 1	6.963	.196	1.018	5.926	.292	1.517		
Item 2	6.519	.279	1.451	5.185	.346	1.798		
Item 3	6.852	.198	1.027	5.630	.303	1.573		
Communication	6.102	.193	1.005	4.741	.197	1.023	6.41	.001
Item 1	6.333	.261	1.359	4.444	.274	1.423		
Item 2	6.148	.175	.907	4.963	.264	1.372		
Item 3	5.630	.312	1.621	5.185	.200	1.029		
Item 4	6.296	.255	1.325	4.370	.347	1.801		
Decision	5.648	.196	1.017	4.759	.247	1.281	2.91	.007
Item 1	5.185	.278	1.442	4.556	.284	1.476		
Item 2	6.111	.222	1.155	4.963	.259	1.344		
Goal	6.167	.217	1.127	5.204	.222	1.154	3.68	.001
Item 1	5.926	.315	1.639	5.444	.179	1.450		
Item 2	6.407	.209	1.083	4.963	.236	1.224		
Control	6.111	.263	1.368	5.037	.247	1.285	3.49	.002
Item 1	5.667	.325	1.687	4.370	.307	1.597		
Item 2	6.556	.258	1.340	5.740	.291	1.514		

TABLE 2

T-Tests of Differences in Real and Ideal Administrative Processes at Pre- and Post-Test Periods (n = 27)

Administrative Process	POST					PRE				
	Mean	Std Dev	Std Err	t Value	Sign	Mean	Std Dev	Std Err	t Value	Sign
Leadership										
Ideal	7.037	.712	.137	8.60	.0001	7.270	.518	.111	6.95	.0001
Real	5.259	1.203	.232			6.358	.716	.138		
Motivation										
Ideal	7.296	.958	.184	7.73	.0001	7.531	.500	.096	6.27	.0001
Real	5.580	1.200	.231			6.778	.847	.163		
Communication										
Ideal	7.129	1.023	.197	10.25	.0001	7.296	.433	.083	7.78	.0001
Real	4.740	.923	.178			6.102	1.005	.193		
Decision										
Ideal	6.741	1.281	.247	6.45	.0001	6.926	.730	.140	6.62	.0001
Real	4.759	1.118	.229			5.648	1.017	.196		
Goal										
Ideal	6.944	1.013	.195	9.90	.0001	7.185	.709	.136	6.32	.0001
Real	5.203	1.154	.222			6.167	1.127	.217		
Control										
Ideal	6.870	1.285	--	9.62	.0001	7.074	.863	.166	-4.70	.0001
Real	5.037	1.285	.247			6.111	1.368	.263		

TABLE 3

Staff Members' Perceptions of Acceptance of Self (AOS) at Pre- and Post-Test Periods (n = 27)

	Mean	Std Dev	Std Err	t Value	Level of Significance
Pre AOS	145.926	16.934	3.259	.64	N.S.
Post AOS	146.963	18.670	3.593		

TABLE 4

Staff Member's Perceptions of Acceptance of Others (AOO) at Pre- and Post-Test Periods (n = 27)

	Mean	Std Dev	Std Err	t Value	Level of Significance
Pre AOO	110.741	6.346	1.221	1.01	N.S.
Post AOO	109.000	8.297	1.597		

TABLE 5

T-Test of Mean Differences in Profile of Conflict Characteristics, (POCC) from Pre- to Post-Test Period (n = 27)

	PRE			POST			t Value	Total Value Signif
	Mean	Std Err	Std Dev	Mean	Std Err	Std Dev		
Total POCC (15 Items)	93.593	2.030	10.548	75.593	2.652	13.779	-5.84	.001
Item 1	5.296	.732	1.207	4.370	.283	1.471		
Item 2	5.630	.251	1.305	4.667	.329	1.710		
Item 3	6.222	.216	1.121	5.333	.745	1.271		
Item 4	7.148	.138	.718	6.185	.200	1.039		
Item 5	6.444	.187	.974	5.037	.309	1.605		
Item 6	6.370	.152	.792	4.963	.247	1.285		
Item 7	6.593	.194	1.101	5.370	.280	1.079		
Item 8	6.593	.153	.797	4.926	.238	1.138		
Item 9	5.667	.261	1.259	4.815	.288	1.495		
Item 10	5.667	.282	1.468	4.370	.273	1.418		
Item 11	6.852	.088	.456	5.519	.216	1.122		
Item 12	6.370	.152	.792	5.259	.174	.903		
Item 13	5.074	.366	1.900	4.000	.297	1.544		
Item 14	6.444	.180	.934	5.444	.216	1.121		
Item 15	6.593	.134	.694	5.333	.714	1.109		

TABLE 6

Pre-Test Pearson Product Correlation Coefficients of Administrative Processes, Real and Ideal, AOS, AOO, and POCC

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	1.0000	-.00047	.2250	.5055*	.1695	.2197	.4587	.0097	.0069	.1754	-.1862	.2253	-.3511	.0890	.3631
2		1.0000	.2985	.5083*	.5238*	.4977*	-.0815	.6829*	.3696	.2937	.3698	.2153	.3044	.2154	.1358
3			1.0000	.2714	.4046*	.3794	-.1267	.0796	.6455*	-.3038	.0669	.1074	.1558	.3147	.2507
4				1.0000	.3300	.4368*	.1253	.2427	.1802	.3779	.0938	.2061	-.0907	.1909	.1510
5					1.0000	.8172*	-.0525	.2351	.4958*	-.0312	.6700*	.3726	.0753	-.0205	.3021
6						1.0000	.0982	.3134	.5750*	.1048	.6817*	.6282*	-.0237	.0256	.3551
7							1.0000	.2510	.0887	.2928	.1072	.4083*	-.4540*	.3242	-.0093
8								1.0000	.4444*	.4455*	.3809*	.4402*	.1582	.4571*	-.1762
9									1.0000	-.0344	.5031*	.4150*	.2272	.4837*	-.0271
10										1.0000	.1947	.4671*	.0246	.1493	-.0740
11											1.0000	.6054*	.1805	.0923	.2213
12												1.0000	-.1062	.2178	.2423
13													1.0000	.2192	-.1434
14														1.0000	-.1407
15															1.0000

Code: 1 = Real Leadership
2 = Real Motivation
3 = Real Communication
4 = Real Decision
5 = Real Goal
6 = Real Control
7 = Ideal Leadership
8 = Ideal Motivation
9 = Ideal Communication
10 = Ideal Decision
11 = Ideal Goal
12 = Ideal Control
13 = Acceptance of Self
14 = Acceptance of Others
15 = Conflict Characteristics

* $p < .05$

TABLE 7

Pearson Product Moment Correlations Between the Real Administrative Process, AOS, AOO, and POCC at Post-Testing

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1	1.0000	.5872*	.7185*	.6326*	.2514	.5449*	.4672*	-.0136	-.0805	-.0992	.0123	-.0561	-.1502	.2761	.6269*
2		1.0000	.6600*	.6895*	.5685*	.6751*	.4938*	.4469*	.4153*	.3343	.4562	.4049*	.2184	.4775*	.5325*
3			1.0000	.8092*	.4172*	.5197*	.4186*	.1404	.2273	.1068	.0413	.1783	.1365	.3831*	.7422*
4				1.0000	.5286*	.6244*	.3052	.2902	.2387	.1659	.2561	.1890	-.0109	.2587	.8362*
5					1.0000	[illegible]	.2869	.5754*	.5291*	.5170*	.6517*	.4849*	-.0077	.5402	.3501
6						1.0000	.6077*	.4125*	.4535*	.4221*	.6073*	.6649*	.1963	.3403	.3923*
7							1.0000	.5973*	.6260*	.6332*	.3674	.5479*	.1197	.2690	.1683
8								1.0000	.8101*	.7462*	.7049*	.6419*	.1891	.2095	.1173
9									1.0000	.8208*	.6712*	.7575*	.3226	.3539	.0368
10										1.0000	.7389*	.7258*	.1947	.3317	-.0490
11											1.0000	.6596*	.2338	.3913*	.0582
12												1.0000	.2767	.2704	-.0113
13													1.0000	.1338	-.1917
14														1.0000	.2695
15															1.0000

Code: 1 = Real Leadership
2 = Real Motivation
3 = Real Communication
4 = Real Decision
5 = Real Goal
6 = Real Control
7 = Ideal Leadership
8 = Ideal Motivation
9 = Ideal Communication
10 = Ideal Decision
11 = Ideal Goal
12 = Ideal Control
13 = Acceptance of Self
14 = Acceptance of Others
15 = Conflict Characteristics

* $p < .05$

TABLE 8

Summary of the Stepwise Regression Analysis of Staff Members' Perceived Conflict Characteristics on Administrative Processes (Real), Acceptance of Self (AOS), and Acceptance of Others (AOO) at Post-Testing
(n = 27)

Variable	Simple R	Multiple R	R Square	R Square Change	F Value	Signif Value
Decision	.83621	.83621	.69924	.69924	58.1241	.001
Accept Self	-.19173	.85593	.73261	.03337	32.8791	.001
Communication	.74221	.87108	.75878	.02617	24.1168	.001
Control	.39282	.87870	.77225	.01346	18.6491	.001
Leader	.63694	.88222	.77831	.00606	14.7456	.001
Accept Others	.26946	.88501	.78325	.00493	12.0451	.001
Goals	.35007	.89133	.79448	.00123	10.4924	.001
Motivation	.53261	.89175	.79522	.00075	8.7376	.001

List of References

Austin, D. R. and Lewko, J. H. "Modifying Attitudes Toward Handicapped Persons in a Camping Environment." Therapeutic Recreation Journal, Vol. 13, No. 3 (1979), 3-6.

Bannon, J. "Management." Parks and Recreation, Vol. 15, No. 7 (July 1980), 32-33.

Barber, W. R. et al. "A Youth Campership Program: A Followup Study of the 1957 Campership Program Administered by the Denver Area Welfare Council, Inc." M.S.W. Group Research Project, University of Denver, 1957.

Beker, J. "The Relationship Between School Camping, Social Climate and Change in Children's Self-concept and Patterns of Social Relationship." Doctoral dissertation, Teachers College, Columbia University, 1959.

Berger, E. "The Relation Between Expressed Acceptance of Self and Expressed Acceptance of Others." Journal of Abnormal Social Psychology, Vol. 47 (1952), 778-782.

Boorman, H. J. "Facilitating the Democratic Process in Camp." Camping in a Democracy. Edited by H. J. Boorman, et al. New York, NY: Association Press, 1941, 15-23.

Carlson, R. E. "The Values of Camping." Camping Magazine (July, 1975), 11-18.

Davidson, M. "Changes in Self-concept and Sociometric Status of Fifth and Sixth Grade Children as Result of Two Different School Camp Curricula." Doctoral dissertation, University of California at Berkeley, 1965.

Department of Health, Education and Welfare. Bureau of Education for the Handicapped (BEH). Physical Education and Recreation for Handicapped Children: A Study Conference on Research and Demonstration Needs. Project No. 182-704. Washington, DC: U.S. Government Printing Office, 1969.

Dibner, S. and Dibner, A. S. Integration or Segregation for the Physically Handicapped Child? Springfield, IL: Charles C. Thomas, 1973.

Doty, R. S. The Character Dimension of Camping. New York, NY: Association Press, 1960.

Duke, J. E. "Changes in Self-concept Following a One-week Resident Outdoor Education Experience." Master's thesis, Pensylvania State University, 1968.

Feldman, R. A. "Socio-behavioral Research in Camp Settings." Penn State HPER Series, No. 11: Research Camping and Environmental Education. Compiled by B. van der Smissen. College of Health, Physical Education and Recreation, Pennsylvania State University, 1976.

Gibb, J. R. and Gibb, L. M. "The Group as a Growing Organism." Group Development. Edited by L.P. Radford. 2nd Edition. LaJolla, CA: University Associates, 1978.

Glick, J. "An Investigation of the Effects of a Two-week Summer Residential Camping Experience." Master's thesis, University of North Carolina, Chapel Hill, 1978.

Hershey, P. and Blanchard, K. H. Management of Organizational Behavior: Utilizing Human Resources. 3rd Edition. Englewood Cliffs, NJ: Prentice-Hall, Inc. 1977.

Herzog, J. D. "Camping for Physically Handicapped Children: A Report of Experiences in Integrating Camping at Camp Hidden Valley." Nervous Child, No. 2 (1956), 66-73.

Holden, H. "Changes in Body Imagery of Physically Handicapped Children Due to Summer Camp Experience." Doctoral dissertation (1960), Dissertation Abstracts, Vol. 21 (1969), 3165, Boston University.

Johnson, D. W. and Johnson, F. P. Joining Together, Group Theory and Skills. Englewood Cliffs, NJ: Prentice Hall, 1976.

Johnson, N. A. "An Investigation of the Values of Campers Who Have Had a Resident Camping Experience." Unpublished master's thesis, Pennsylvania State University, 1970.

Kreiger, W. "Effects of an Organized Camping Experience on Self-concept Change in Relation to Three Variables: Ages, Sex and Observable Behavior." Doctoral dissertation, University of New Mexico, 1970. Dissertation Abstracts, Vol. 33, 200-201A.

Leadley, S. M. "Leadership Strategies: Communicating is Leading. Penn State HPER Series, No. 11: Research Camping and Environmental Education. Compiled by B. van der Smissen. College of Health, Physical Education, and Research, Pennsylvania State University, 1976, 309-322.

Lefebrve, C. G. "The Comparative Effects of Three- and Six-Week Periods of Residential Camping on Physical Fitness and Adaptive Behavior in children and Youth with Brain Dysfunction Syndromes." Doctoral dissertation (1972), Dissertation Abstracts, Vol. 33, New York University, 200-201A.

Lewko, J. H., et al. "Communication Patterns of Counselors Working with Handicapped Children." Therapeutic Recreation Journal, Vol. 12, No. 4 (1978), 36-42.

Likert, R. and Likert, J. G. New Ways of Managing Conflict. New York, NY: McGraw-Hill, 1976.

McGuire, E. D. "The Effect of a Camping Experience on Physically Impaired Children's Self-concept and Attitudes Toward Other Similarly Impaired Children." Master's thesis, Pennsylvania State University, 1976.

Meyers, L. E. "Personnel Preparations and Recreation/Leisure Opportunities for Handicapped Persons." Focus on Research Recreation for Disabled Individuals. Washington, DC: Regional Rehabilitation Research Institute, George Washington University, 1980, 107-120.

Myers, J. L. "A Summary of Resident Camp Leadership Research." Penn State HPER Series, No. 11: Research Camping and Environmental Education. Compiled by B. van der Smissen. College of Health, Physical Education and Recreation, Pennsylvania State University, 1976, 349-362.

_____. "The Association Between Leadership Components of the Resident Camp Experience and Camper Development in Self-concept, Interpersonal Affect and Environmental Attitudes." Doctoral dissertation, Pennsylvania State University, 1978.

Randolph, K. D. "A Survey of the Pre-camp Counselor Training Program in Camps for Handicapped Children." Master's thesis, State University of Iowa, 1956.

Rappaport, B. M. "The Effect of a Residential Summer Camp Experience on the Self-Concept of Boys Suffering from Pseudohypertrophic Muscular Dystrophy." Unpublished master's thesis, Pennsylvania State University, 1974.

Redl, F. "Psychopathic Risks of Camplife." Camping Therapy: Its Uses in Psychiatry and Rehabilitation. Edited by T.P. Lowry. Springfield, IL: Charles C. Thomas, 1974.

Ross, M. E. "The Effectiveness of a Three-day Pre-camp Training Program for Staff in a Summer Residential Camp for Physically Handicapped Children." Master's thesis, Pennsylvania State University, 1971.

Sessoms, H. D. et al. Study of the Effects of Handicapped Children: Final Report Camp Easter-in-the-Pines. University of North Carolina-Chapel Hill, 1978.

Wittekin, R. G. "Program Themes at a Psychiatric Day Camp." Camping Therapy: Its Uses in Psychiatry and Rehabilitation. Edited by T. P. Lowry. Springfield, IL: Charles C. Thomas, 1974.

PHILOSOPHICAL BASIS FOR THERAPEUTIC RECREATION AND LEISURE LIFESTYLE ADJUSTMENT IN THERAPEUTIC CARDIAC REHABILITATION

Gene A. Hayes*
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> Play is good for losing weight and reducing our risk factors. For relieving stress and returning us to work relaxed. Play maintains our health and promotes our longevity. Compensates for needs not met at work, and provides a harmless way to vent antisocial emotions. Play, the experts say, is a necessity in a leisure society (Sheehan, p. 79).

Introduction

Research has provided us with adequate knowledge about the physical factors that make a person likely to develop heart disease. The one most likely to develop heart disease is an older male with high levels of cholesterol or other fats in his blood, high blood pressure, diabetes,

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parents who suffered heart disease; a man who is fat, exercises little, and smokes at least one pack of cigarettes a day. However, having knowledge of all of these factors which lead to arteriosclerosis does little to help identify new victims of heart disease. Most individuals who are afflicted with heart disease do not have excessive levels of cholesterol, only a few are hypertensive, and fewer still have diabetes.

ABC's of Type A Behavior. In recent years, researchers have expanded their efforts to include psychological factors as they relate to heart disease and heart attacks. Most authorities have reached some agreement that stress and Type A behavior are the primary psychological causes of heart attacks. Type A behavior is indicative of the highly competitive, time-pressured individual who reacts to frustration with hostility. The Type A individual, although seemingly in control of his environment and lifestyle, is in actuality driven and controlled by his lifestyle and environmental forces. The individual is highly achievement and success oriented and pushes himself to near capacity as he attempts to attain the difficult-to-reach goals. The person who exhibits Type A behavior rarely relaxes during leisure. If play, leisure, or recreation activities are engaged in, they are most usually done with the same intensity and drive as are their work-related counterparts. It is extremely difficult for Type A individuals to balance their lifestyles with appropriate levels of avocational and vocational pursuits and to escape the constant threat of self-imposed life stress. An over-zealous commitment to work with resulting difficulty in relaxing, an aggressive drive for success, and a constant need to maintain a full-speed-ahead pace of life's activities are the traits of the

Type A personality that are implicated as risk factors for coronary disease (Liljefors & Rahe, 1970).

R_x for Cardiac or Potential Victims. The process of effective rehabilitation for the cardiac patient, or for the individual who exhibits a dangerously high incidence of heart disease risk factors, should include not only physical activities which will increase the functional capacity of the individual, but also activities that will promote positive lifestyle adjustments to reduce, or to eliminate, the precipitating causes of heart disease. The most commonly accepted method of facilitating the patient's adjustments or lifestyle modifications is through some form of patient education or counseling program which will assist in raising the individual's level of awareness of the dangers of associated risk factors such as smoking, obesity, diet, lack of exercise, hypertension, high cholesterol, stress, and stress-related conditions.

All indications are that a change in lifestyle that results in a lowering of the risk factors will go a long way toward preventing heart disease. Many studies show that lifestyle has more influence on heart disease than heredity or geographic location. "Americans have made changes in their lifestyle and these changes have been parelleled by very significant drops in death rates due to heart disease and stroke" (Vickery, 1978).

Leisure, Play, and Exercise in Lifestyle Adjustment

In his book, Running and Being: The Total Experience, Dr. George Sheehan gives us some advice on coping with our lives from birth until death and how we can increase our chances of living healthy and happy lives free from heart disease.

> "I know only two things," a student said to Rollo May. "One, I will be dead someday; two, I am not dead now. The only question is what I shall do between those two points." Sport and play and exercise are essential to that doing, that being, that becoming. They are concerned with physiology, not disease; with health, not heart attacks; with fitness, not lessening of hypertension, strokes or other human ills (Sheehan, 1978, p. 68).

More credence is given to the theory that lifestyle has a tremendous impact on an individual's health by the results of a study by Dr. Victor Fuchs (Vickery, 1978). This study compared the mortality in the states of Utah and Nevada. The level of income and medical care in the two states were similar, although Nevada had more doctors per resident than Utah. The predominant lifestyles, however, were quite different. The influence of the nonsmoking, nondrinking, family-oriented Mormons was felt throughout Utah. The results of Fuch's study showed that the death rate was much higher in Nevada in all groups, and almost six times as many young men (under age 40) in Nevada die from lung cancer and cirrhosis of the liver -- all diseases of lifestyle and all preventable deaths.

We would be wise to follow the advise of Nietzsche. "Attend," he said, "to the little things." Take care with your nutrition. Watch your diet. Be careful about where you live and the air you breathe. Do not commit a blunder at any price in the choice of your recreation. Develop an instinct for self-defense. Make your life a matter of play (Sheehan, 1978, p. 58).

Anxiety and depression are two major psychological hurdles in cardiac rehabilitation according to Hackett and Cassem (1978). Other researchers have also identified

these same reactions as major problems within the rehabilitation process. These psychological reactions are illustrative of the ways in which people tend to react to stressful situations. Hackett and Cassem describe anxiety as a state similar to fear, such as a fear of impending death. They define depression as a "state of sadness due to a loss" (Hackett & Cassem, 1978, p. 244). This is one of the strongest psychological barriers to cardiac rehabilitation.

Change Through Exercise. Most cardiac rehabilitation programs in the United States are utilizing physical exercises for coping with psychological problems faced by many cardiac patients (Nagle, 1975; Wilhelmsen, 1975). This approach has proven to be very effective. Specific training will reduce anxiety and depression and is effective in relieving general tension (Higdon, 1978; Langosh, 1976). Naughton (1975) reports on a study involving several control groups: one group engaged in an exercise program, one group meditated, and a third group sat in comfortable chairs in a sound-filtered room. All three groups in the study showed definite reductions in levels of psychological stress. The researcher suggested that the psychological benefits attributed to exercise may not be intrinsic to exercise, but rather a function of taking "time-out" to escape the stresses of modern civilization.

Indeed, the need for escape might be more crucial to the psychological well-being of the patient than the exercise in and of itself. Driver and Knopf (1976) indicated that recreational activities are utilized by people in order to help satisfy desires that cannot be, or for some reasons are not, satisfied during non-recreational time.

Wolf (1969) cited lack of satisfying leisure lifestyle as a psychological stressor contributing to coronary disease.

The cardiac patient classically experiences depression of varied duration and intensity. Exercise has been found to substantially alleviate these states of depression; however, Naughton (1975) points out that it may not be the exercise itself as much as the escape from the stressors of modern living that the exercise provides. In addition to this escape, leisure activities might also be able to provide a lessening of psychological stresses and to provide an alternative means of attaining satisfaction which the patient usually derives from participating in activities that are now inappropriate. Wrzesniewski (1976) concludes that myocardial infarction precludes the realization of many needs and that the patient has very little opportunity to find new means of obtaining satisfactions.

Pierce (1980) has equated job satisfaction with satisfaction derived from leisure. By utilizing the results of the Pierce study, it could be inferred that the cardiac patient who cannot return to work might be able to attain equivalent satisfaction from appropriately selected forms of leisure activity. By utilizing Wrzesniewski's research, it may be inferred that providing an acceptable alternative for the achievement of satisfaction, leisure activities may, as part of the rehabilitation process, provide patients a means of achieving meaningful satisfactions never before facilitated through other forms of interaction.

The above information would seem to indicate that the importance of an appropriate leisure lifestyle, especially for the individual with heart disease, is greater than had been previously thought.

Therapeutic Recreation and Leisure Adjustment Programming

In a dissertation by Hoeft, several aspects of leisure and therapeutic recreation for the cardiac patient were discussed. One important segment of Hoeft's dissertation dealt with the utilization of therapeutic recreation specialists as members of the cardiac rehabilitation team. Hoeft (1978, p. 56) writes:

> In discussing the composition of cardiac teams, Landry and Palko (1972) and Fox (1978) include recreational therapists and personnel. Fox suggests that recreational therapists can help relieve depression and be instrumental to the individual leisure lifestyle. Landry and Palko state that there exists a need for better coordination or preventive and rehabilitation services to integrate other "helping services" including recreational specialists, in the promotion of health and fitness.

A number of other medical and physiological experts in the field of cardiac rehabilitation suggest that the inclusion of therapeutic recreation specialists on the rehabilitation team is both appropriate and desirable (Hellerstein, 1978; Meyer, 1975; Oldridge, 1977; Stoedefalke, 1978; Wilson, 1975).

Among the goals of cardiac rehabilitation/intervention programs as presented by the American Heart Association (1978) are the following: (a) to improve the quality of life for the surviving heart attack client, and (b) to educate or reeducate clients to become more confident and competent in achieving a healthy and constructive lifestyle. Both of these goals relate directly to the nature of the contribution that a therapeutic recreation specialist can make to the rehabilitation process for the quality of life, and a healthy lifestyle of a client must

be largely composed of appropriate and selective leisure pursuits.

Dr. Hoeft (1978, p. 58) summarizes the approach of Dr. C. R. Meyer (1975) in the following manner:

> Dr. Meyer suggests that coronary prevention centers should foster the client's development of "new expressions in the use of leisure time and greater self-understanding" (p. 266). If total rehabilitation/intervention are to provide comprehensive services to their clients, these needs must be met on a systematic basis.

The systematic basis to which Dr. Hoeft refers must include the input of the therapeutic recreation specialist, the professional staff person with the knowledge and expertise in an area of need that increases the patient's chances for achieving a complete and meaningful recovery.

Current Survey Findings. The authors surveyed ten leading cardiac rehabilitation programs across the United States to discover the extent to which they use therapeutic recreation personnel and leisure programming in the total rehabilitation process. A six-item interview questionnaire was developed, and each of the ten cardiac rehabilitation centers was called. The questions were posed to one of the direct supervisors of each of the cardiac centers, i.e., the center director.

The first question asked of the directors was, "Is your clients' participation in recreation and leisure activities of concern to you?" Every one of the respondents (100%) indicated that they were concerned with the leisure lifestyle and involvement of the clients. In response to the question, "Do you have someone in your program who deals directly with the clients to assess and program leisure activities; and if so, what background and training does this person have?", some variation was seen. Five of the

cardiac center directors indicated that they had a staff member (in some cases more than one) responsible for leisure programming. The two types of staff members most commonly charged with this responsibility were: (1) nurses, approximately 56% of the time, and (2) physical therapists, about 20% of the time. Two other staff members with direct responsibility for leisure programming, but to a much lesser extent, were the staff physiologist and the exercise leader. This response, although appearing somewhat positive, is in actuality misleading. There appears to be a lack of organization, structure, and time commitment with regard to the assessment and programming of leisure and therapeutic recreation activities for cardiac clients.

The directors were asked, "How much time does the staff person spend with the clients in matters relating directly to leisure involvement?" In cardiac programs that last typically from six to nine months, there was less than a minimal amount of time devoted to structured assessment and programming of therapeutic recreation and leisure, if it happened at all. When this did occur, it covered a total of less than twenty minutes for the entire nine-month rehabilitation program.

Question Four was directed more to those centers which did not have a leisure or therapeutic recreation component: "If the client's leisure lifestyle is important, and you do not have a leisure or therapeutic assessment and programming process, what are your plans regarding such?" Two of the five centers that had nothing organized said they planned some type of staff discussion regarding the need for this type of service; the rest said nothing. As part of Question Four, the directors of the centers that had some type of leisure or therapeutic recreation involvement were asked about their plans for future expansion of this

area. Three of the five had no plans. One of the centers indicated that a specialist might be hired in the near future, and another center indicated that recreation therapy would be part of the occupational/physical therapy team.

"Is therapeutic recreation/leisure assessment and programming developed in conjunction with other areas, e.g., exercise program, vocational counseling, psychology, etc.?" Question Five elicited the following information. Since there were no separate recreation components or staff in the five centers providing some leisure programming, this process was developed in conjunction with other services in all cases. In one center, therapeutic recreation was part of the occupational therapy area. Other areas that dealt with leisure concerns were vocational counseling and psychosocial readjustment; leisure concerns also surfaced during the total educational and counseling process. The responses seemed to indicate that when clients expressed concerns regarding their leisure or recreation, they were dealt with at the time by the staff member who was asked the question.

The final question asked was, "Of the total amount of time spent with the clients, how much deals with therapeutic recreation/leisure, exercise physiology, vocational counseling, psychosocial readjustment, other concerns?" It should be expected that a large portion of time is devoted to the exercise physiology component as this is the main thrust of the program. In terms of the estimated percentage of time spent with the cardiac client, 76.5% was concerned with the exercise physiology, 13% was concerned with psychosocial readjustment, 8% with vocational rehabilitation counseling, 2% with recreation and leisure, and 1% of

the time was spent with the client in matters of other concerns.

Clearly, it is evident from the results of this interview process with the directors of ten of the leading cardiac rehabilitation centers in the United States that therapeutic recreation and leisure programming is an area of concern and that specific expertise in this area is needed in these cardiac rehabilitation programs. It is just as evident that the professional staff involved in conducting the cardiac rehabilitation programs are not aware of the contributions that the therapeutic recreation specialist can make to the total rehabilitation program for the cardiac client. It remains the responsibility of therapeutic recreation specialists to demonstrate the nature and value of their particular speciality to the other professional staff.

Goals of Cardiac Rehabilitation: The Inclusion of Therapeutic Recreation

The goal of cardiac rehabilitation appears to be fairly consistent among rehabilitation centers. A common statement regarding the goal of rehabilitation for the cardiac client is as follows: "The ultimate goal is to return the patient to a suitable, productive occupation through vocational counseling." There is no question in anyone's mind that having the ability to work interrupted either permanently or temporarily is a devastating blow to an individual. It is even more stressful when this interrupting force is something as traumatic as a heart attack.

As important as "work" is to the individual and to the individual's ability to maintain his personal integrity, his self-concept, and his self-image, it is not the only

aspect of rehabilitation that should receive major attention. For instance, there will be a sizeable percentage of the cardiac clients who will not be returning to work at all, or perhaps only in some modified fashion. However, all of the heart attack survivors, and all of the individuals suffering any form of heart disease, will have leisure time. Many of these individuals will, in fact, have increased free time on their hands, albeit enforced and unwanted free time. Thus, there will be an increased need for appropriate leisure pursuits for these individuals. The importance of work and leisure is further emphasized when we look at the four most common questions asked by a heart attack victim (Hellerstein, 1978): 1) "Will I live? 2) When can I have sex? 3) When can I go back to work? 4) When can I start playing again?" Obviously, from the patient's perspective, living, loving, working, and playing are of utmost concern and should all receive adequate attention during the rehabilitation process.

An Important Role for T.R. Specialists. The therapeutic recreation specialist can provide the expertise to assist the cardiac client to learn to live again through leisure, play, and recreation. The role of the therapeutic recreation specialist would include assisting the client through leisure education and leisure awareness sessions in modifying his leisure lifestyle including self-understanding, self-awareness, and the ability to alleviate or eliminate stress through leisure, play, and recreation. The therapeutic recreation specialist can provide the role model that says to the client, "I am ready to start a new religion, the first law of which is 'play regularly'. An hour's play a day makes a man whole and healthy and long-lived. A man's exercise must be play, or it will do him

little good. It may even, as we see regularly in the press, kill him" (Sheehan, p. 76).

Some authorities in the area of cardiac rehabilitation suggest that there is a need for education focusing on enjoyable activities (Stoedefalke, 1978) and others suggest that a good exercise program must focus on attributes indicated by the individual letters of the word "variation": V = variety, A = aerobic, R = relaxing and recreative, I = individualized, A = attitude, T = therapeutic, I = isotonic, O = objective testing, and N = noncompetitive and fun" (Oldridge, 1977, p. 86). Variety is essential to the comprehensive rehabilitation program as this will increase the probability that the individual will discover some interest that can be shared with family members, that can be done at home or on vacations or business trips. This will also increase the possibility that the individual client will join a community group to continue his interests. The therapeutic recreation specialist will possess the versatility to expose the clients to a variety of leisure possibilities, will have the capability of involving the clients in stress and tension reduction activities, and will have the community contacts to help the clients move into the community in search of appropriate leisure pursuits.

Summary

The age in which we are living has been given several names. However, the two most popular seem to be "The Age of Boredom" and "The Age of Lifestyle". Both designations have far-reaching implications for society, and the two are seemingly interrelated. Many individuals can cope with boredom if they have managed their lifestyle well. Sheehan

(1978, p. 101) says, "Boredom, like beauty, is in the mind of the beholder." He also quotes Chesterton: "There is no such thing as an uninteresting subject. The only thing that can exist is an uninterested person." The individual suffering from "boredom" will most assuredly have, or will develop, other physical or psychological illnesses which can be alleviated through appropriate leisure lifestyle adjustments.

Dr. Donal Vickery (1978, p.22) tells us, "Put simply, we have gotten just about all the help we can expect from the environment and medical care. We are now firmly in the grip of our own habits. Whatever substantial improvements or decline in health we experience must relate to how we live." There are many indications that our individual lifestyles affect our health and our longevity (Vickery, 1978). Each individual is the master of his own fate in terms of his health and happiness. For individuals afflicted with heart disease, it is apparent that they have not developed appropriate healthy lifestyle behavioral patterns, and they now need the advice, care, and treatment of professional staff trained in cardiac rehabilitation. These individuals are probably best represented in the following parable, "Join the Coronary Thrombosis Club," written by L. A. Harris:

> Never say "No," accept all invitations to meetings, banquets, committees; why have drive if you don't use it?
>
> Go to the office evenings, Saturdays, Sundays and Holidays. Your job comes first; personal consideration is secondary.
>
> Take the briefcase home evenings and weekends. You can then review all the troubles and worries at your leisure.
>
> If you hold night meetings, be on the job early the next morning. Tomorrow is another meeting.

Don't eat restful, relaxing meals; always plan a conference for the meal hour or rush out and grab a "quickie".

Never attend meetings as it is wasting valuable time hearing of new ideas and methods instead of devoting time to details.

Believe it a poor policy to take all the vacation allowed you. Keep in touch with the office daily.

If your work calls for travelling, work all day and drive all night to keep the next morning's appointment.

Regard fishing, hunting, travelling, gardening as a waste of time and money.

Above all, after your leaders have gone to bed, get those reports and registrations in workable order for the next day.

Never delegate responsibility to others -- carry the entire load yourself.

AND THEN -- DROP DEAD!

The hard driving professional person, a Type A personality, may work this way for years and not suffer any trauma. On the other hand, the chances of this type of individual suffering a heart attack are greatly increased by his lifestyle, which produces tremendous amounts of stress and tension. This individual has an urgent need for exposure to a professional intervention program which must include therapeutic recreation and leisure involvement.

Lifestyle Must be Top Priority. Medical science will advance, but it will not be able to undo what we have done to ourselves. Lifestyle readjustment is crucial for the millions of individuals who have some form of heart disease for the control and possible eradication of the associated risk factors. For the individuals who are free from heart disease, a greater emphasis should be placed on living a lifestyle, especially a leisure lifestyle, that exhibits

the antithesis of "coronary prone behavior patterns" if a full, healthy, and happy life is to be expected.

List of References

American Heart Association. Heart Facts. American Heart Association, Inc., 1977.

Driver, B. L., and Knopf, R. C. "Temporary Escape: One Product of Sport Fisheries Management." Fisheries, Vol. 1, No. 2 (1976), 21, 24-29.

Hackett, T. P., and Cassem, N. H. "Psychologic Aspects of Rehabilitation After Myocardial Infarction." Rehabilitation of the Coronary Patient. Edited by N. K. Wenger and H. K. Hellerstein. New York, NY: John Wiley and Sons, 1978.

Hellerstein, H. K. "Rehabilitation of the Post-infarction Patient." Hospital Practice, Vol. 7, No. 42 (1972).

_____. Cardiac Rehabilitation in Retrospect. Session VI, Cardiac Rehabilitation in Perspective, Heart Disease and Rehabilitation Symposium, Milwaukee, Wisconsin, May, 1978.

Higdon, H. "Can Running Cure Mental Illness?" Runner's World, Vol. 13, No. 1 (1978), 36-43.

Hoeft, T. M. The Effects of Leisure Counseling Upon Selected Attitudes of Potential Cardiac Clients. Unpublished doctoral dissertation, Virginia Polytechnic Institute and State University, 1979.

Langosh, W. "Personality Structure and Actual Condition of Patients with Heart Diseases." Psychological Approach to the Rehabilitation of Coronary Patients. Edited by U. Stocksmeier. Springer-Verlag, 1976.

Liljefors, I., and Rahe, R. H. "An Identical Twin Study of Psychosocial Factors in Coronary Heart Disease in Sweden." Psychosomatic Medicine, Vol. 32 (1970), 523-542.

Nagle, F. J. "Cardiovascular Effects of Exercise." Adult Fitness and Cardiac Rehabilitation. Edited by P. K. Wilson. Baltimore, MD: University Park Press, 1975.

Oldridge, N. B. "What to Look for in an Exercise Class Leader." The Physician and Sports Medicine, (April, 1977), 85-88.

Pierce, R. "Dimensions of Leisure." Journal of Leisure Research, Vol. 12, No. 1 (1980).

Sheehan, G. A. Running and Being: The Total Experience. New York, NY: Warner Books, 1981.

Stoedefalke, K. "The Exercise Clinic." Research in the College of Health, Physical Education and Recreation. Pennsylvania State University, March, 1978, 6-7.

Vickery, D. M. Life Plan for Your Health. Reading, MA: Addison-Wesley Publishing Co., 1978.

Wilhelmsen, L., et al. "A Controlled Trial of Physical Training After Myocardial Infarction." Preventative Medicine, Vol. 4 (1975), 491-508.

Wilson, P. K., ed. Adult Fitness and Cardiac Rehabilitation. Baltimore, MD: University Park Press, 1975.

Wolf, S. "Psychosocial Forces in Myocardial Infarction and Sudden Death." Research on Acute Myocardial Infarction. Edited by S. Bondurant. New York, NY: American Heart Association, 1969.

Wrzesniewski, K. "Some Psychotherapeutic Problems of Patients After Myocardial Infarction." Psychological Approach to the Rehabilitation of Coronary Patients. Edited by U. Stocksmeier. Springer-Verlag, 1976.

Chapter 15

LEISURE COUNSELING: A COMPONENT OF CARDIAC REHABILITATION AND HEART DISEASE INTERVENTION PROGRAMS

Thea M. Hoeft*

Introduction

Currently the therapeutic recreation profession has been in the process of synthesizing the speciality of leisure counseling. Specific leisure counseling models (Burk, 1975; Eason, 1972; Edwards, 1975; Fearn, et al., 1974; Fulton, 1973; Hayes, 1977; Jowiak, 1975; McDowell, 1976; Overs, 1970; Overs, et al., 1971, 1974a, 1974b; Wilson and Mirenda, 1975) have proliferated in an attempt to provide a systematic process by which individuals can develop a more satisfying meaningful leisure lifestyle and become aware of their leisure and work values and the personal expressions of these values. Still in its infancy, the concept of leisure counseling is being used to provide a more comprehensive leisure service for the purposes of education, rehabilitation and recreational involvement (Peterson, 1977).

Coupled with a growth of leisure counseling has been the growth and development of cardiac rehabilitation (also

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referred to as cardiac therapy) and intervention programs designed in part to reduce the risk factors involved with cardiovascular diseases. These programs have been a response to the fact that according to the American Heart Association (1978), in the United States alone, more than 29 million individuals are afflicted with cardiovascular diseases, accounting for one million deaths each year. Because this represents the Number One cause of death in the United States today, the medical, health and allied health professions are in the process of developing comprehensive rehabilitation and intervention programs to meet the medical, physical, social, vocational and nutritional needs of individuals with hypertension, arteriosclerosis, heart attacks, by-pass surgery, stroke and congenital heart defects.

Sustained exercise has been identified as an effective component of cardiac rehabilitation (therapy) and intervention programs in fostering the cardiac client's increased cardiovascular functioning and general well-being (Brenner, et al., 1960; Fox, 1972; Fox, 1977; Morris, et al., 1973; Nagel, 1975; Naughton, 1975).

Lifestyle: Controlled and Uncontrolled Factors

Few references are made concerning the assessment and enhancement of the cardiac client's and his/her family's leisure attitudes, interests, satisfaction, and leisure self-concepts, although Wolf (1966) has indicated that in post-myocardial clients, as well as in high-risk cardiac clients, a lack of leisure satisfaction correlates with psychological stress -- a factor which may increase the incidence of coronary heart disease.

Although some risk factors such as age, sex, race, and a predisposition or heredity toward heart disease cannot be changed, diet, high blood pressure, diabetes, stress, cigarette smoking, exercise and leisure satisfaction can be medically controlled or changed by the individual.

Although individual cardiac rehabilitation therapy program goals vary, the American Heart Association (1978) has identified the following goals: 1) returning to gainful employment, independent living or self-care; 2) reducing or minimizing patient and family economic burden resulting from heart attack by working toward a short hospital stay and maximum speedy recovery; 3) reducing the risk of another heart attack through re-education and implementation of a secondary prevention program; 4) improving the quality of life for the surviving heart attack victim and the family (p. 21).

In discussing the development of cardiac rehabilitation and intervention programs, Dr. Zohman (1975) states that cardiac rehabilitation is more than exercise for individuals. She clarifies this distinction by stating that a cardiac rehabilitation program "includes not only exercise, medical supervision and dietary counseling, but psychological counseling, vocational counseling and efforts to lessen other risk factors such as smoking and hypertension" (p. 180). The use of counseling is seen by some cardiac rehabilitation programs as an important aspect of their services; however, little attention, evidenced by lack of research, has been given to the use of leisure counseling in fostering the cardiac client's leisure satisfaction and total well-being.

One recent research study (Hoeft, 1979), utilizing McDowell's leisure counseling model with adult subjects in a cardiac intervention program, concluded that leisure

counseling positively increased the clients' leisure self-concept and leisure satisfaction on a short term basis.

Leisure Activities and Cardiac Rehabilitation Therapy/Intervention Programs

In reviewing the subject of recreation and leisure in cardiac rehabilitation and intervention programs, the limited literature mentions three distinct areas: 1) recreation personnel as part of the treatment team; 2) the need for recreational and leisure activities; and 3) the inclusion of a leisure activity history on clients' records who are being screened for coronary risk factors and programs.

In discussing the composition of cardiac rehabilitation teams, Landry & Palko (1972) and Fox (1978) include recreational therapists and recreation personnel. Fox (1978) suggests that recreational therapists can help relieve depression and be instrumental in fostering the individual's leisure lifestyle. Landry and Palko (1972) state that there exists a need for better coordination of prevention and rehabilitative services to integrate other "helping services" including recreational specialists, and to promote and maintain health and fitness.

Oldridge (1977) suggests that a good exercise leader may be a recreation specialist. It is evident that the role of the recreation specialist as a member of the cardiac rehabilitation/intervention team is unclear, but as their recent mention in the literature becomes a reality on cardiac treatment teams, their role functin may be clarified.

Goals of cardiac rehabilitation/intervention programs broadly state that they aim to educate to reduce risk factors, improve the quality of life for the surviving heart

attack client, and educate or re-educate clients to become more confident and competent in achieving a healthy and constructive lifestyle (American Heart Association, 1978; Kavanagh, 1972). Dr. Hellerstein (1978) has identified four unmet needs and limitations of current cardiac rehabilitation/intervention methods that relate directly to the previously mentioned goals: 1) the need to provide proof of effect -- how much exercise is necessary; 2) the limitation of a preoccupation with physical training; 3) the lack of integration into a comprehensive care system; and 4) the neglect of social and vocational adjustment of the client.

Variation

Some programs suggest the need for education in enjoyable activities (Stoedefalke, 1978) and that "good" exercise programs contain the attributes spelled out in the word "variation." "V - variety, A - aerobic, R - relaxing and recreative, I - individualized, A - attitude, T - therapeutic, I - isotonic, O - objective testing, N - noncompetitive and fun" (Oldridge, 1977, p. 86). A variety of activities are essential as they increase the likelihood that the activity will be carried over to family involvements, vacation time and to individual activities during business trips. Oldridge (1977) also suggests that the individual may join some other recreational groups in the community under his own initiative because of the stimulating variety of activities to which he has been exposed in the rehabilitation/intervention program. "Recreative type activities should be stressed, as these can be pursued with the family and other groups during leisure hours" (p. 87). Activities of a recreational nature should be based on the individual's needs and interests, but no mention is made of

how and who may assess the client's leisure interests. Although they state the need for recreational and leisure activities, both Oldridge (1977) and Stoedefalke (1978) fall short of mentioning leisure counseling as a means of implementing these individualized activities in the client's total lifestyle.

Educate/Motivate

Clients' attitudes toward the value of activity may be lacking and "the leader's function is educative in that he should help the client change his lifestyle in constructive ways. Education of the client as to his choice of activities and the therapeutic value of the activity is always important especially when he does so without supervision" (Oldridge, 1977, p. 87).

Dr. Meyer (1975) also suggests that coronary prevention centers should foster the client's development of "new expressions in the use of leisure time and greater self-understanding" (p. 226).

Although program referral information may include a section on the client's activity status in an attempt to assess the past and present recreational activity, it is not systematically collected or used to enhance the client's lifestyle (Wilson, 1975). A history of the client's leisure activities should not only be used as a basis for individual exercise prescriptions but to help the clients change their lifestyles in constructive ways. Using increased leisure time in passive activities rather than active ones contributes to an increasingly unhealthy lifestyle which can be changed through patient education and counseling (Lalonde, 1972; World Health Association, 1973).

The Role of Leisure Counseling

Utilizing what McDowell (1977) identifies as four leisure counseling orientations -- leisure-related behavior problems, leisure lifestyle awareness, leisure resource guidance, and leisure skills development -- and Allen and Hamilton's (1980) fifth orientation -- counseling through activity involvement -- the role of leisure counseling can be integrated within the typical cardiac program phases. Although these phases vary between the many private, federal and state medical centers, hospitals, universities and other community facilities offering services, Figure 1 illustrates some typical phases.

Which leisure counseling orientation is utilized, or if several are utilized simultaneously, is dependent upon the client's situation and the counselor's training. As Allen and Hamilton (1980) accurately state, "If leisure is viewed as a medium for assisting in the resolution of psychological or emotional problems that pervade all aspects of an individual's life (orientation five), then advanced training in psychological counseling is necessary" (p. 21).

The role of the leisure counselor within cardiac rehabilitation/intervention programs needs to be clarified in cooperation with other members of the treatment team. Currently psychological and emotional counseling in many programs is offered by a psychologist or social worker. As cardiac rehabilitation/intervention programs become more comprehensive in nature, leisure counseling as a service has expanding potential. Like other organizations these programs try to make their services attractive and beneficial to potential clients. The integration of leisure counseling as a service enhances the many rehabilitative

and interventive modalities now being provided. The challenge to the therapeutic recreation profession is to provide trained leisure counselors and recreational therapists to fulfill an important service component within such programs.

Appendix

Fig. 1--Typical Cardiac Program Phases

In Patient Phase

Phase I - Acute Phase

Immediately following acute myocardial infarction to the fifth day or one to three days post-operative care after open heart surgery.

Leisure Counseling Component

1. Assist in patient and family lifestyle assessment including leisure habits.
2. Assist in educating the patient and family about the rehabilitation program and schedule.

Phase II - Recovery and Rehabilitation Phase

Post-acute phase in which the patient and family are educated about the coronary heart disease process, behavioral responses observed in cardiac patients and the multiplicity of alternatives for risk factor modification.

Leisure Counseling Component

1. Assist in planning individualized home exercise and leisure activity program.
2. Conduct relaxation therapy sessions.
3. Design and conduct classes for the patient and family concerning the modification of individual leisure lifestyles.

4. Individual counseling may be required if previous leisure lifestyle has been identified as a stress factor or current review of leisure lifestyle indicates severe stress.
5. Assist in preparing materials for self-study related to leisure lifestyle integrated with activities of daily living and other risk factor modifications.
6. If qualified, the leisure counselor may assist on an individual basis with problem areas (i.e., typical behavioral responses of anxiety, anger or depression) non-specific to leisure.

Phase III - Discharge

Patients follow individualized rehabilitation programs designed prior to discharge or may enter Phase IV, outpatient maintenance conditioning or intervention.

1. Follow-up leisure lifestyle assessments and designing home leisure programs.
2. Resource referral to community organizations providing specific leisure services including additional leisure counseling.

Outpatient Phase

Phase IV - Maintenance Conditioning or Intervention

Clients are referred after discharge by physicians to participate in a monitored program and are apparently healthy adults who wish to reduce their personal risk of coronary heart disease through a scientifically designed exercise, diet program and other risk factor consultations. Some programs allow the patient to participate for an extended period of time while others refer to Y.M.C.A.'s and other community organizations.

Leisure Counseling Component

1. Assist in leisure skills development integrated with individual exercise prescriptions.

2. Assist the multidisciplinary team (physicians, physical therapist, social worker, dietitian, occupational therapist, exercise leaders and cardiac program coordinator) with client progress review.
3. Design educational clinics that explore leisure lifestyles, leisure awareness, and community resources.
4. Individualized counseling if needed for problem areas not specific to leisure.

List of References

Allen, L. R. and Hamilton, E. J. "Leisure Counseling: A Continuum of Services." Therapeutic Recreation Journal, Vol. 14, No. 1 (1980), 17-22.

American Heart Association. Heart Facts, American Heart Association, Inc., 1977.

Burk, G. "A Community-based Model for the Delivery of Leisure Counseling Services to Special Populations." Unpublished master's project, Department of Recreation Education, University of Iowa, 1975.

Brunner, D. and Manelis, G. "Myocardial Infarction Among Members of Communal Settlements in Israel." Lancet, Vol. 2 (1960), 1049.

Eason, J. "Lifestyle Counseling for a Reluctant Leisure Class." Personnel and Guidance Journal, Vol. 51, No. 2 (1972), 127-132.

Edwards, P. "Leisure Counseling Techniques." Individual and Group Counseling Step-by-step. Los Angeles, CA: University Publishers, 1975.

Fearn, J., O'Brien, S., and Prosser, L. "Leisure Education Lifestyle Center." Program proposal abstract, University of Oregon, 1974.

Fox, S. "Exercise and Coronary Heart Disease." Proceedings of the National Conference on Fitness and Health. Ministry of National Health and Welfare, Ottowa, Canada, 1972.

_____, Naughton, J. P., and Gorman, P. A. "Physical Activity and Cardiovascular Health." Modern Concepts of Cardiovascular Disease, Vol. 41, No. 17 (1972).

_____. "Scope of the Problem." Session I, Introductory Remarks, Heart Disease and Rehabilitation. Heart Disease and Rehabilitation Symposium, Milwaukee, WI, May, 1978.

_____. "Physical Activity in the Community." Prevention of Heart Attack - A Challenge to Health Professions. Edited by G. A. Hellmuth. University Microfilms International, 1977.

Fulton, K. "Humanistic Life-style Counseling Model." Recreation and Leisure Services - A Humanistic Perspective. Edited by J. Murphy. Dubuque, IA: Wm. C. Brown Co. Pub., 1975.

Hayes, G. "Model for Leisure Education and Counseling in Therapeutic Recreation." University of Waterloo, Waterloo, Ontario, Canada, 1974.

Hellerstein, H. "Cardiac Rehabilitation in Retrospect." Session VI, Cardiac Rehabilitation in Perspective, Heart Disease and Rehabilitation Symposium, Milwaukee, WI, May, 1978.

Hoeft, T. M. "The Effect of Leisure Counseling upon Selected Attitudes of Potential Cardiac Clients." Unpublished doctoral dissertation, Virginia Polytechnic Institute and State University, 1979.

Joswiak, K. "The Design, Implementation and Evaluation of Leisure Counseling Program Materials for Use With Mentally Impaired Adults in a Group Home Setting." Unpublished master's project, Michigan State University, 1975.

Kavanagh, T. "Post Coronary Exercise Programs." Proceedings of the National Conference on Fitness and Health. Ministry of National Health and Welfare, Ottawa, Canada, 1972.

McDowell, C. F. Leisure Counseling: Selected Lifestyle Processes. Eugene, OR: Center of Leisure Studies, University of Oregon, 1976.

Morris, J. N., et al. "Vigorous Exercise in Leisure Time and the Incidence of Coronary Heart Disease." Lancet, Vol. 1 (1973), 333.

Myers, C. R. "Future Directions of YMCA Physical Fitness." Adult Fitness and Cardiac Rehabilitation. Edited by P. K. Wilson. Baltimore, MD: University Park Press, 1975.

Nagle, F. J. "Cardiovascular Effects of Exercise." Adult Fitness and Cardiac Rehabilitation. Edited by P. K. Wilson. Baltimore, MD: University Park Press, 1975.

Naughton, J. P. "Physical Activity and Coronary Heart Disease." Adult Fitness and Cardiac Rehabilitation. Edited by P. K. Wilson. Baltimore, MD: University Park Press, 1975.

Oldridge, Neil B. "What to Look for in an Exercise Class Leader." The Physician and Sports Medicine, (April, 1977), 85-88.

Overs, R. P. and Healy, J. R. Educating Stroke Patient Families, Vol. 1. Curative Workshop of Milwaukee, Milwaukee, MI, July, 1971.

_____, Taylor, S., and Adkins, C. Avocational Counseling in Milwaukee. Final Report. Curative Workshop of Milwaukee, Milwaukee, WI, May, 1974.

Stoedefalke, K. "The Exercise Clinic." Research in the College of Health, Physical Education and Recreation. Pennsylvania State University, March, 1978, 6-7.

Wilson, G. T., Mirenda, J. J. and Rutkowski, B. H. "Milwaukee Leisure Counseling Model." Leisureability, Vol. 2, No. 3 (July, 1975), 11-17.

Wolf, S. "Psychosocial Forces in Myocardial Infarction and Sudden Death." Research on Acute Myocardial Infarction. Edited by S. Bondurant. New York, NY: American Heart Association, 1969.

Zohman, L. R. "Philosophy of Exercise Testing and Exercise Programs." Adult Fitness and Cardiac Rehabilitation. Edited by P. K. Wilson. Baltimore, MD: University Park Press, 1975.

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INDEX

accountability 16, 18-19, 21
accreditation 6, 27, 94
  re-evaluation 107
activity
  analysis 7, 33
  Assessment Inventory 138, 139, 140, 141-144
  values of 4
administrative skills 61
advocacy 11, 61
advocate 20, 25
Age of Boredom 187
Age of Lifestyle 187
All Handicapped Children Act 22
American Heart Association 181, 194, 195, 197
American Recreation Society Section on Hospital Recreation 6
attributions 135
attribution theory 34, 133-144
  advantages 139
  defined 134-135
  disadvantages 140
  dispositional 135
  environmental 135
  programming 137
attitudes 19, 36
assessment skills 18, 60
awareness 19

barriers 133
  attitudinal 134
  social and psychological 134
barriers (cont.)
  fulfillment 133, 134
behavior modification 61
behavioral outcomes 137
Berger Questionnaire 158
biofeedback 69-86
  characteristics 82, 83
  defined 71
  self-regulation 71
  use of with chronic pain patients 72
block grants 22
boredom 10
brain activity 121, 132
brainstorming 127
Brown, Charlie 121

Camp Daddy Allen 157, 158, 161, 162
campers 35-37
camper-staff interaction 37
camping 154-155, 159, 161-163
  benefits 154
  conflict of staff 161, 162
  decision-making process 160, 163
  democratic-decentralized environment 161
  "ideal organization" 159
  importance of camp staff 155
  literature 153
  organized

camping (cont.)
movement 154
pre-camp training 162
pre-professional preparation 163
research 153, 154, 155
special populations 154, 155
staff perceptions 156, 159, 160
cardiac rehabilitation 177, 181, 182, 194, 195, 199
limitations 197
physical exercise 179
psychological hurdles 178
cardiac rehabilitation centers 182, 183, 184, 185
cardiovascular diseases 175, 194
case study design 42
Center for Health Assessment and Treatment 72
certification 6, 61
change agents 146
client motivation 32, 38
Client Performance Documentation Forms (FPEP) 48
civil rights act 18
communication skills 145, 146
competencies 110
clusters 115
identifying 111
operationalizing 115
conflict resolution 163
constructive discontent 122, 132
Coronary Thrombosis Club 188
counseling skills 61
creativity 121-132
adaptation 128
brainstorming 127
piggy-backing 129
potential 123
re-naming 131
re-ordering 130
space 124
strategies 122
valuing 125
creative power 124
creative people, characteristics 122
curricula 2, 64
increase 99
curriculum 64, 87, 92, 95-99, 109-120, 163
competency based 109, 110
competency clusters 115, 118
components for evaluation 92
content 92, 95
development process 118
doctoral-level 110
evaluation 87, 117-118
goals 92, 95, 98
growth 99
guidance 92, 97
implementation/monitoring 110
instructional transactions 92, 97
learning hierarchy 116, 117
organization 92, 96
degrees 60
Delphi technique 115, 118

deregulation 21, 25
  historical perspective 24
diagnostician 11
dianostic/prescriptive skills 60
diversion 3

Easter Seal Society of Pennsylvania 157
education 60
Education for All Handicapped Children Act, 1975 17
educational
  preparation 100
  training 100
emotional disorders 70
enjoyable imagery 72, 74, 76, 77
equal opportunity 16, 17, 19
exercise program, "Variation" 187, 197
Experimental Design 72
Era of Limits 29
evaluation 42-55
  descriptive 44
  limitations of 52
  internal 42, 52
  objectives-oriented models of 90
  process 11, 12, 92
  professional judgment models of 90
  program 45
  transaction-observation models of 90
evaluation model 46
evaluator 11

facilitator 20, 25
facilitator/advocate role 20, 21
facilities, long-term care 18
faculty 102
  educational background 100
  experience 102
  rank 101
faculty level training 100
federal
  assistance 6
  government 15
financial support 22, 23
flowchart 45
Formative Program Evaluation Procedure (FPEP) 42, 43, 44, 47, 48, 50, 51, 52, 53
FPEP
  limitations 53
  purpose 53
funding 21, 22

goals 26
Golden Valley, Minnesota 72
government
  decreased influence 21
  regulations 21
Great Depression 2

habit 122, 127
handicapped, attitudes toward the 36
helping professions 145
Hipples Interpersonal Relationship Rating Scale (IRRS) 148
homeostatic state 71

hospital conferences 3
hospital recreation 3
value 5
human happiness 133
human relations training 146
human service delivery, purpose 22, 133
professional 15
professions 15
worker 145

idealism 3
imagery biofeedback 72
independent leisure functioning 139
participation 33, 34, 38
interpersonal relationship skills 145-152
interpersonal skills
components 146
need 147, 150, 151
interviews 88, 90
intrinsic motivation 31, 32

Jacobson's relaxation technique 70
Joint Commission on Standards for Educational Evaluation 45
Joint Commission on the Accreditation of Hospitals 27

learning hierarchy 116, 117
legislation 17
Leisure Attitude Scale 73
leisure
attitudes 72, 77
counseling 193, 195, 199
education 31, 32
expression 10
intervention strategy 31
participation 32, 34
services provision 41
skill development 62
licensing 61
lifestyle change 177, 178, 188, 189
locus of control 35, 36

Maine 59
mainstreaming 17
management 146
management by objectives 12
Massachusetts 59
Medicare 18
funding 18
medicine 60
medical models 82
mental health facilities 60
mental retardation facilities 60
Michigan University Speech and Hearing Camp 35, 36, 37
Mormons 178
Minnesota Multiphasic Personality Inventory (MMPI) 73
mission 12
multi-modal model of curriculum evaluation 87-98
defined 88, 91
use of 93
muscle-cerebral feedback loop 70

National Therapeutic Recreation Society 26-27
New England 59
New Hampshire 59
Nevada
  mortality 178
Nietzsche 178
North Carolina
  First Hospital 1
  State Hospital 3
NRPA/AALR Accreditation 107

observation 88, 90
occupational
  prestige 65
opportunity to
  create 125
organized camp 36

pain
  clinic 70
  self-regulation 71
participant assessment techniques 18
patient evaluation 61
participation 33
Pepperment Patty 121
perceptual-cerebral
  feedback loop 70
philosophical alternatives 26
physical, motor
  skill development 62
piggy-backing 129
play
  pathological 2
  values 176
positive projection 123
Post Session Report
  Form (FPEP) 48, 49, 50
poverty 127
practical experience 100
  of faculty 103
preventative
  health care 69
pride 122, 126
profession
  basic role of 9
  identify of 1
  strengths of 25
  uniqueness of 9, 12
professional
  identity 1
professional/
  practical experience 100
professionalism 5, 65
professional
  awareness 58
Profile of Conflict
  Characteristics
  (POOC) 158, 159
Profile of Organizational Characteristics Form
  SLM 157, 158
program evaluation 41, 42, 45
  models 44
program plans 18
programming 35
progressive relaxation 70
Proposition 13 24
psychology 60
psychosomatic
  disorders 70
puissance test 113, 115

Quality Space
  Matrix 113
Quieting Response
  Training 74
questionnaires 88, 90

recreation 2, 7
  for special
    populations 8
  resources 138
  specialists 6, 10, 181, 186, 196

recreation (cont.)
therapy 8, 136
treatment 8
recreational
status 60
therapists 60
recreators
dilemma 32
our role 10
reexamination 25
registration 27
rehabilitation
function of
T R in 62
Rehabilitation Act
of 1973 17, 22
Section 504 17
relaxation 69-86
learned 70
skills, benefits 84
reinforcing creativity 125
Russian Roulette 2

self-actualization 146
self-concept 33-35, 38
self-image 35
self-imposed
stress 176
sensitivity
training 146
social dance 131
social
skill development 62
trends 16, 23
work 60
SPRE Catalog 101
Special Olympics 57
special populations 31
specialization 4
speech and language pathologists 37
standards 18
stress 85

team process 64
terminal behavior 118
therapeutic,
discipline 1
therapeutic recreation 7, 8, 57
alternatives 28
challenges 13, 15
concept of 6, 7
continuing
education 87
current accomplishments 25
curriculum 107
definition 8, 31, 57, 58
faculty 101-105
function of 62
intervention 7
intervention
strategies 33, 38
mission 9, 10
motivation 13
perceptions of 59
philosophy 20
profession,
control 16
professional
growth 66
professionals 34
perceptions of 59
professionals'
attitude 36
program, defined 43
research 31
services 25, 32
status 63, 65
uniqueness of 9
therapeutic recreationists 7
uniqueness 12
therapeutic recreation specialist 6
as a catalyst 34, 38
skills of 11
therapy 7
participatory/
self-care 84

treatment
  goals 32
  plan 139
trend analysis 79
triangulation 88
  defined 91
Type A Behavior 176

unequal participation 19
unit directors 57, 62
Utah, mortality 178

Vermont 59
Vocational Rehabilitation Administration 6

Washington, D.C.
  sit-in 17
wellness 85
wholeness 132
Wilcoxon Signed-Ranks Test 149
Work-A-Holics 132
World Health Association 198
work-leisure satisfactions, substitutability 180
World War II 1

YMCA 201